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# Report

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TO THE MARYLAND  
BOARD OF PHYSICIANS

SUBMITTED BY  
THE UNIVERSITY OF MARYLAND, BALTIMORE

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JULY 2012

*This report was prepared under a Memorandum of Understanding (MOU) between the Maryland Board of Physicians and the University of Maryland, Baltimore, dated April 2, 2012.*

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July 23, 2012

Members of the Maryland Board of Physicians  
4201 Patterson Avenue  
Baltimore, Maryland 21215

Ladies and Gentlemen:

The University of Maryland, Baltimore submits this report to provide guidance to the Maryland Board of Physicians as requested in the Memorandum of Understanding (MOU), effective April 2, 2012, between the University of Maryland, Baltimore and the Maryland Board of Physicians. As set forth in the MOU, our report was written: "(1) to assist the Board in evaluating its complaint resolution procedures; (2) to assist the Board in preparing a response to Complaint Resolution Issues identified in Chapter 3 of the Evaluation of the State Board of Physicians and the Related Allied Health Advisory Committees issued by the Department of Legislative Services, Office of Policy Analysis, November 2011; and (3) to provide analysis and advice concerning other issues addressed in that Evaluation, as recommended by the University and as determined appropriated by the Board after consultation with the University."

Our goal in writing the report and making recommendations was to assist the Board to streamline and more timely discharge its responsibilities to protect the public through licensing, regulation, and education while ensuring accountability, transparency, and fairness throughout the process. We recognize and commend the Board members for their dedication and commitment to the work of the Board and the essential services they perform for the State. We hope that you find our recommendations useful as you continue your valuable efforts. We would be pleased to comment on any legislation that may result from this report.

Sincerely,



Jay A. Perman, MD

cc: Joshua Sharfstein, MD, Secretary, Department of Health and Mental Hygiene



# **REPORT TO THE MARYLAND BOARD OF PHYSICIANS SUBMITTED BY THE UNIVERSITY OF MARYLAND, BALTIMORE JULY 2012**

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## **I. INTRODUCTION**

This report was prepared under a Memorandum of Understanding (MOU) between the Maryland Board of Physicians and the University of Maryland, Baltimore, dated April 2, 2012. The MOU called for the University to provide guidance to the Maryland Board of Physicians in: (1) evaluating its complaint resolution procedures; (2) responding to the “Sunset Review” Report issued by the Department of Legislative Services (November 2011); and (3) meeting the Board’s statutory responsibilities. Under the MOU, the University agreed to:

- 1) Conduct a review of relevant laws, regulations, procedures, reports, and other documents pertaining to the Maryland Board and staff operations;
- 2) Conduct interviews with Board staff and others;
- 3) Observe Board meetings and daily operations;
- 4) Prepare recommendations based on interviews and observations that would include:
  - a) Identification of a process for implementing key recommendations in the Sunset Report and requirements from past and current legislation;
  - b) Creation of a plan of action to address openness and transparency concerns regarding Board reviews and actions; and
  - c) Discussions of draft recommendations with Board members and the Secretary of the Department of Health and Mental Hygiene; and
- 5) Prepare legislative testimony relating to our findings and recommendations.

Beyond the specific MOU requirements, the University also:

- 1) Conducted a literature review of pertinent materials, such as information from the Federation of State Medical Boards, the U.S. Department of Health and Human Services, and other recognized source materials;
- 2) Met with and reviewed written comments and materials from representatives of the Maryland Board of Physicians, Board staff, allied health advisory committees of the Board, Department of Legislative Services, Department of Health and Mental Hygiene, Office of the Attorney General, Office of Administrative Hearings, Board’s peer review entity, other licensing boards, and medical and allied health associations; and
- 3) Contacted staff or board members from other states that may be models for Maryland.

The individuals who developed this report include Jay Perman, MD, President, University of Maryland, Baltimore; Diane Hoffmann, JD, MS, Professor of Law and Director, Law & Health Care Program, University of Maryland Francis King Carey School of Law; Barbara Klein, MPA, Associate Vice President, Government and Community Affairs, University of Maryland, Baltimore; and Donald Swikert, MD, former member of the Kentucky Board of Physicians.

Members of our team attended meetings of the full Board, the Investigative Review Panel and Case Resolution Conference. Based on our attendance at these meetings and the interviews we conducted, we commend the Board members for their dedication and commitment to the work of the Board. We recognize the extensive time commitment required by the members and the essential services they perform for the State. Our goal in writing this report and making these recommendations was to assist the Board to streamline and more timely discharge its responsibilities to protect the public through licensing, regulation and education and ensure accountability, transparency and fairness throughout the process.

Although our report refers in numerous places to the 2011 Sunset Report, we did not attempt to address each of the 46 recommendations made in that document. Rather, our recommendations attempt to provide structural and process changes that will strengthen the Board and provide a reasonable foundation to correct many of the types of problems identified in the Sunset Review Report.

In assessing the present Board structures and functions, we were guided by the principles of responsibility, empowerment, accountability, confidentiality, fairness, and timeliness. These principles are generally recognized by the Federation of State Medical Boards as essential for medical boards as they carry out their paramount goal of protecting the public and the public's right to know.

## **REFERENCES**

Key words used throughout this report are defined below and any reference to the law is to the Annotated Code of Maryland, Health-Occupations Article, unless otherwise stated:

- Board - refers to the Maryland Board of Physicians
- Board Member - refers to an appointee to the Board of Physicians
- Chair - refers to the Chair of the Maryland Board of Physicians
- DHMH - refers to the Department of Health and Mental Hygiene
- Executive Director - refers to the Executive Director of the Maryland Board of Physicians
- OAG - refers to the Office of the Attorney General
- OAH - refers to the Office of Administrative Hearings
- Secretary – refers to the Secretary of the Department of Health and Mental Hygiene
- Staff - refers to the staff and/or agency that supports the Maryland Board of Physicians operations

## **II. EXECUTIVE SUMMARY**

We are recommending the following actions, the rationale for which is explained in the body of the report. **Key recommendations are noted with an \*(asterisk).**

1. **\* The Maryland General Assembly should amend the Medical Practice Act to establish two separate panels to hear disciplinary cases, each acting separately. Each would have the authority to make a final determination in a case. See Appendix B for a flowchart of the proposed process.**
2. **\* The Board, under its existing authority should seek to implement and encourage additional informal processes for case resolution.**
3. **\* The Board should have available to it additional access to and time of attorneys within the OAG, both Board counsel and prosecutors, and have the opportunity to provide feedback to supervisory personnel at the OAG about the legal work that is performed by the prosecutors and Board counsel.**
4. **\* A representative of the allied health professions advisory committee should participate as an ex-officio member in Board disciplinary processes when a member of their profession is the subject of a disciplinary proceeding.**
5. **\* The Secretary of DHMH in collaboration with the OAG should establish timeframes for Board and attorney actions based on case complexity and whether the case is a matter for summary suspension.**
6. **\* The Board should finalize and implement sanctioning guidelines for physicians and allied health professionals as soon as possible.**
7. **The Board should acquire or develop the expertise to review and evaluate fraud and self-referral cases.**
8. **Board counsel and/or prosecutors should collaborate with Board staff to develop templates for investigators to use in gathering evidence.**
9. **\* Other than for exceptional cases, the Maryland General Assembly should authorize the Board to use only one peer reviewer (in addition to the Board's internal medical reviewer) in standard of care cases.**
10. **The OAH should designate a smaller pool of Administrative Law Judges (ALJs) with training in medical matters to hear Board cases and the Board should assist in the training of those ALJs.**
11. **The Maryland General Assembly should adopt a "statement of policy" guiding the actions of the Board of Physicians.**
12. **\* The Maryland General Assembly should increase the Board size from 21 to 22 members, including making a change in Board composition, and divide disciplinary matters between two panels.**

13. The Board should require orientation training for new members and ongoing training for all Board members.
14. \* The Maryland General Assembly should consolidate and more clearly delineate the duties and powers of the Board.
15. \* The Board should establish committees to assure adequate oversight of agency operations.
16. \* The Board and Executive Director should take proactive steps to increase educational outreach and transparency.
17. The Secretary and Board should define the responsibilities and expectations of the Executive Director, who should be held accountable for agency operations.
18. The Board and Executive Director should consider further actions to enhance administrative functions.

**APPENDIX A** sets forth a summary of the recommendations and identifies the state entity with responsibility for the recommended actions.



### **III. COMPLAINT RESOLUTION PROCEDURES**

A primary focus of the MOU centered around guidance to the Board on its complaint resolution process. We recognize that the paramount responsibility of the Board is the protection of the public, and the Board must be both fair and efficient in carrying out this function through its disciplinary process. We therefore considered many of the questions raised by the 2009 Task Force on Discipline of Health Care Professionals and Improved Patient Care. In developing its recommendations the Task Force attempted to address both issues of fairness of process and fairness of outcomes. In terms of process, the Task Force asked whether the Board was being fair to complainants in terms of responsiveness, timeliness, the investigation process, confidentiality, and whether sanctions were appropriate and justified for any decision reached. The Task Force also considered the same issues in terms of fairness to respondents.

Regarding efficiency or timeliness, the Task Force asked: (1) whether the health occupations boards were handling cases in a “timely” fashion and, if not, whether there were areas for improvement including prioritization of cases, investigations, consent orders, formal hearings, standard of care cases, and peer review; (2) whether the boards have goals for timeliness of case resolution; (3) to what extent the boards are in compliance with existing goals or standards; and (4) what barriers exist to timely case resolution. These questions also formed the foundation of our review of the Board of Physician complaint resolution procedures.

#### **A. Current Process**

The majority of the Board’s time is devoted to disciplinary actions resulting from complaints and investigation of licensee actions. The current process affords licensees all legally required due process protections but is unduly formal and lengthy. Indeed, many of the deficiencies noted by the 2011 Sunset Review of the Board relate to the complaint resolution process. The general flow of routine cases that come before the Board begins with receipt of a complaint by the Board’s compliance unit. Complaints may be received from patients or their family members; health care providers and institutions; local, state or federal agencies, other boards; or the Board may initiate complaints based on reports in the media or other publicly available sources of information. The Board also reviews and investigates anonymous complaints. The Board receives, on average, over 940 complaints per year; the majority are based on either immoral or unprofessional conduct in the practice of medicine [Md. Health Occ. Art., Sec. 14 -404 (3)] or failure to meet the relevant standard of care [Md. Health Occ. Art., Sec. 14-404 (19) and (22)] (also see 2011 Sunset Review Report, p. 33-34). A description of the complaint resolution process is provided in the 2011 Sunset Review Report (see p. 27 – 31). We used that description as a foundation for this report. We also gathered additional information about the process from individuals with whom we spoke and included that information when relevant.

A complaint once received is reviewed by Board staff (investigators in the Investigations Unit) who contact the licensee and complainant and engage in a “triage” effort to determine the seriousness of the complaint and how quickly the Board must take action. A preliminary investigation may also include review of medical records and hospital quality assurance files. If appropriate, the complaint may also be reviewed by the Board’s in-house medical consultant. At the present time, the Board employs one part-time medical consultant. The Board intends to hire a second full-time medical consultant. This would give the Board 1.5 FTEs (full-time equivalents) of a medical consultant. In addition to reviewing standard of care cases, peer reviewers have recently also been asked to provide an opinion in cases involving unprofessional conduct. During this time, the Board investigatory staff, if necessary, seeks

advice on legal matters from Board counsel. Prosecutors may also offer assistance during the investigation phase to provide direction as to what is needed for an adequate investigation (see Sunset Report, p. 43); although it is not clear how often this actually happens. Any cases identified that may require summary suspension are also handled by the prosecutors.

Once the preliminary investigation is complete, together with the background investigatory information, it is referred to the Board's Investigative Review Panel (IRP). The Panel currently includes seven board members. Board counsel also attends Panel meetings. The Panel may close the case, often with an advisory letter to the licensee; refer the case back to Board staff for further investigation; or vote to send the case to the Board for charging if there is sufficient evidence.

According to the 2011 Sunset Report and interviews with several individuals who participate in the disciplinary process, a large majority of the cases are closed after they are reviewed by the IRP. During the past year (July 2011 – June 2012), 82% of cases presented to the IRP for the first time were closed. If not closed, the case returns to the IRP, after subsequent staff investigation, where a decision is made to close the case with an advisory letter or refer the case back to the Board staff for a full investigation. At this stage, board investigatory staff will engage in further investigation (which may include subpoenas for documents and testimony) and, if the complaint involves a standard of care issue and/or overutilization of health care services, the case is referred to an external peer review organization. Currently, the Board has a contract with Permilion for peer review. Permilion is an accredited independent review organization that provides external medical peer reviews and independent health care review services for government agencies and large health care providers. It is located in Westerville, Ohio. All cases sent out for peer review are reviewed by two external reviewers as required by statute [Md. Health Occ. Art., Sec. 14-401(e) (1) (ii)]. If the two reviewers do not agree, the Board typically uses a third peer reviewer. The 2011 Sunset Review Report indicated that the average number of days for peer review declined by 13% or 12 days between 2007 and 2011. For the first six months of 2011, the average number of days reported for external peer review was 77.

After the full investigation is completed, the case is brought to the full Board which votes whether to charge the licensee with disciplinary violation(s). The case is reviewed by a prosecutor for legal sufficiency before it is sent to the Board for charging (see Sunset Report, p. 43.). A "prosecutor of the month," from a pool of a small number of prosecutors, is assigned to the Board by the OAG; that prosecutor reviews cases and investigations with staff once per month. If the Board votes to charge, the case is sent to the OAG for prosecution.

At this stage, the case is handled by the prosecution arm of the OAG. The OAG operates under a 1994 "Guideline for Administrative Adjudicatory Proceedings", effectively establishing a "Chinese wall" to "insulate AAsG from possible conflicts" in their roles of representation of and advisors to the Board and prosecution of cases that come before the Board. While this role division is not required by US or Maryland Constitution or statute [See *Withrow v. Larkin*, 421 US 35 (1974)], the OAG has voluntarily implemented the guidelines to provide "fair adjudications to those affected by State agency action"; "vigorously present cases before a decision-maker" when performing the advocacy function; and "provide well-informed advice" to its clients. Recent amendments to the Health- Occupations Article (2010, Sec. 1 - 609) require that each health occupations board is to collaborate with the OAG to make guidelines available to the public concerning the separate roles for AAsG and prosecutors. On July 5, 2012 the guidelines were posted on the Board's website.

The prosecutors review the case and prepare a formal charging document. Although the prosecutor reviews the case for legal sufficiency before it goes to the Board for charging, we were told by individuals we interviewed that in some cases prosecutors determine after the Board votes to charge that there is insufficient evidence with which to charge and the case is sent back to the Board investigators for further investigatory work. This significantly delays the charging process. Recent discussions between prosecutors and Board staff, however, indicate that prosecutors may become more involved in the process earlier to provide better guidance to investigative staff. This may reduce the likelihood that cases are sent back to investigators to gather additional evidence. Also, prosecutors, rather than the investigator, are now required to make the presentation to the Board regarding any case that is being returned to the Board for dismissal.

Once the prosecutors draft the charges, the charging document is served on the licensee/respondent. (Board counsel recently started reviewing charging documents. The Board, however, at its meeting on June 27, 2012, approved a proposal to have prosecutors sign off on the charging documents.) The charges are made public (i.e., posted on the Board website) after they are served on the licensee. When the charging document is finalized, the prosecutors schedule a hearing date with the Office of Administrative Hearings (OAH) for a hearing before an administrative law judge (ALJ).

After the licensee/respondent receives the charges, he/she is offered an opportunity to meet with the Case Resolution Conference (CRC), which is a subcommittee of the Board composed of five Board members. Occasionally, the Board votes a pre-charge consent order or votes to offer a pre-charge letter of surrender. In these situations, the prosecutor will negotiate with the licensee prior to charges being issued. In the large majority of situations, however, there are no pre-charge negotiations. Prior to a formal hearing with an ALJ, the respondent is given an opportunity for an informal resolution of the charges against him or her at a CRC meeting. The meeting is voluntary, informal and confidential. If an agreement is reached between the CRC and the respondent, the prosecutor drafts a consent order. The proposed consent order is then sent to opposing counsel and Board counsel for review. Once the proposed Consent Order is agreed upon by the parties and Board counsel, the respondent signs the Consent Order and sends it to the full Board. The full Board then considers and votes to approve the Consent Order. The Board, through its staff, then monitors the terms and conditions of the agreement to ensure compliance by the respondent. If no agreement is reached at this stage, or if the respondent elects not to meet with the CRC, the case goes to a hearing before an administrative law judge (ALJ) appointed by the Office of Administrative Hearings. Twenty- three ALJs, out of a total of approximately 60 ALJs, were assigned to Board of Physician cases during the last fiscal year.

Following the hearing, the ALJ issues proposed findings of fact, conclusions of law and a sanctioning recommendation. The ALJ, by statute, has 90 days to issue his/her opinion. In FY 2012 the OAH met this deadline 100% of the time. Once the ALJ decision is issued, the parties (prosecutors and respondent) may file exceptions to the ALJ decision. Those exceptions must be filed with the Board, and an exceptions hearing is held before the full Board. At the hearing, the Board may accept or deny the exceptions. Whether or not exceptions are filed, the full Board issues a decision affirming or rejecting the ALJ decision and imposing sanctions. Recently, the Board adopted sanctioning guidelines as required under legislation passed in 2010 (SB 291/HB 533; 2010 Laws of Maryland, Chapter 533/534) to ensure that similar cases receive similar sanctions. The Board is required by statute to post each final, public order for a disciplinary sanction issued to a licensee on its website [Health Occ. Art., Sec. 1-607]. The respondent's compliance with the final order is monitored by Board staff. If staff finds that the respondent is not complying with the final order, the Board may take further action against the licensee, pending a show cause hearing. The respondent can file an appeal with the courts, but the final Board

action is in effect pending any court decision. Also, in any case that is appealed to the courts, the Board is represented by Board counsel.

Any agreement reached with a licensee (formal or informal) or final decision reached by the Board after a hearing that restricts a license in any way, e.g., chaperone requirements, proctoring or mentoring, or practice contingent on meeting educational requirements, are public and not confidential. They are also reported to the National Practitioner Data Bank and posted on the Board's website. For a physician or physician assistant, any agreement or final decision is also reported to the Federation of State Medical Boards.

## **B. Issues/Concerns Raised About the Disciplinary Process**

Many of the issues raised in the 2011 Sunset Review regarding the complaint resolution process were echoed by individuals with whom we met and interviewed. Below we list issues which were raised in the Sunset Report that were affirmed by our interviews or in our discussions with various participants in the disciplinary process. A number of these issues were also raised in the 2009 Report of the Task Force on Discipline of Health Care Professionals and Improved Patient Care.

1. The Board process is unduly complex and lengthy.
2. The Board process is too formal and does not allow sufficiently for informal resolution of cases prior to drafting of charges.
3. Board operations are, in some cases, an inefficient use of members' valuable time.
4. The layers of Board review cause unnecessary delay.
5. Board members appear to have unclear expectations of the role of legal counsel (both Board counsel and prosecutors).
6. The Board makes insufficient use of advisory committees for allied health professionals when specific expertise may be useful.
7. The backlog of disciplinary cases is far too long and Board members are not informed of the backlog.
8. Parties are allowed extensive time to present cases and guidelines imposing time limits for oral remarks by both parties are not consistently imposed.
9. The Board and prosecutors in the disciplinary process lack clear timeframes for their work.
10. Fragmentation and multiple handoffs result in complications in the orderly progression of the disciplinary process, which impedes unified management of case flow, raises costs and diminishes accountability in adhering to timely completion of the process.
11. Quorums can be difficult to reach or maintain at current panel meetings.
12. Sanctions on allied health professionals are perceived as harsher than those for physicians.

The majority of concerns relate to the efficiency of Board operations. By statute, the Board is required to dispose of complaints "as expeditiously as possible and, in any event, within 18 months after the complaint was received by the board." [Md. Health Occ. Sec. 14 – 401(k) (1)]. Although this appears to be mandatory language, it has been interpreted by the Maryland courts to be directory only, and the Board is not bound by it. [See *Solomon v. Board of Physician Quality Assurance*, 132 Md. App. 447 (2000), cert den. 360 Md. 275 (2000)]. According to the 2011 Sunset Review (p. 37), "The number of cases not resolved within 18 months, although falling from a high of 211 in fiscal 2007, remains at over 150 cases per fiscal year. This includes the majority of cases that go through the complete complaint resolution process." The Review also found that the complaint resolution times in general are increasing, and that the increase in time was primarily due to two factors: "the time taken to get cases

to OAG and the time taken to get formal charges signed and executed have both lengthened. . . .” The Report provides some explanation for these increases:

1. “Compliance analysts are preparing more complete investigative reports. While more complete investigative reports reduce the time a case is in OAG and lessen the need for OAG to send a case back to the board for additional investigation, the time it takes for board staff to prepare these reports increases.” (This is despite the fact that the board has more analysts and a lower average caseload.)
2. “The number of cases referred to OAG for charging has increased, while the number of prosecutors assigned to the board has not. According to the OAG, in calendar 2005, 54 cases were referred for formal charges compared with 84 cases in 2009 and 133 cases in 2010. Currently, five full-time and two part-time prosecutors work on the board’s cases.”
3. “The number of summary suspensions referred to OAG has significantly increased as well. This affects the ability of OAG to work on cases because the nature of the case requires the prosecutor to begin work on it immediately and basically stop working on all other cases. A summary suspension case ties up a prosecutor for at least three months.” (See 2011 Sunset Report, p. 41-42).

### **C. Recommendations**

As discussed above, our recommendations in this section focus on improving the efficiency of the workings of the Board while maintaining or improving the due process provided to licensees.

**Key recommendations are noted with an \*(asterisk).**

#### **Recommendation 1:**

**\* The Maryland General Assembly should amend the Medical Practice Act to establish two separate panels to hear disciplinary cases, each acting separately. Each would have the authority to make a final determination in a case. See Appendix B for a flowchart of the proposed process.**

To improve Board efficiency and provide greater due process protections, the Board should establish two separate panels to address disciplinary cases. Each disciplinary panel may deal with investigation and charging (i.e., serve as both an IRP and a CRC), as well as adjudication and discipline, but not for the same case, i.e., if Disciplinary Panel A determines that charges are appropriate for a specific case, it may not participate in the adjudication and disciplinary determination of that case (after the case has been referred to the OAH). Thus,

- A disciplinary panel, at any meeting, may act at times as an investigating panel and a disciplinary panel.
- A disciplinary panel that acts as an investigating/charging panel for a particular physician or allied health professional must not act as the disciplinary panel. Thus, the disciplinary phase of a complaint will be given to the other panel.
- Each panel would have the authority to approve a final decision.
- Each panel may also enter into voluntary settlements with respondents at any time during the process.

Each panel would consist of 11 members, enabling more effective use of Board members’ time and most importantly, more timely action on disciplinary matters. Because the panels are smaller than the full board and more likely to meet less frequently than currently required of the IRP and CRC, it is more likely that a quorum would be met than under the current process. A quorum would consist of 6 of the

11 members. Each panel would include three public members, one allied health professional, one academic medical representative, and six physicians. The Board Chair would select the chair of each panel. The Board Chair would serve as a member of one panel and could serve as an ex-officio member of the other panel. We believe that, once the Board's backlog of cases is reduced, the time commitment required of Board members under this two panel system will be less than the time required under the current Board process.

This recommendation is similar to one made by the 2009 Task Force on Discipline of Health Care Professionals and Improved Patient Care. The Task Force Report (p.17), which reviewed all health occupations boards, made the following recommendation:

To the extent practicable, each board should have a subcommittee which will decide whether charges should be brought against a licensee. The members of this subcommittee shall not participate in any hearing on the charges or any final decision by the board on the charges or sanctions imposed based on those charges. Only members of this subcommittee can participate in investigations and pre-adjudication case resolution conferences.

The rationale for this recommendation was that several task force members "expressed their concern that, if a board member is involved in investigating and charging a provider, that board member will not be able to participate fairly in a subsequent hearing and sanctioning process. This is based on the concern that a board member who participates in investigating a provider and later votes to charge a provider will be unfairly biased by the information he or she gleaned during the investigation and charging process. This background might make it difficult for the board member to subsequently hear the case objectively." While this rationale focused on concerns of fairness to the licensee, we believe that the establishment of two panels also will expedite the review of disciplinary cases, and thus enhance the protection of the public.

The Task Force recommendation was adopted in part by legislation (SB 291) but we do not believe the current law goes far enough. The statute [Health Occ. Art., Sec. 1-602] provides that:

- (A) After consultation with the Secretary to the extent permitted by existing administrative and fiscal resources, each health occupations board shall establish a disciplinary subcommittee.
- (B) To the extent deemed practicable by each board, a disciplinary subcommittee shall:
  - (1) Be responsible for the investigation of complaints;
  - (2) Determine whether the health occupations board should bring charges against a licensee or certificate holder; and
  - (3) Participate in pre-adjudication case resolution conferences resulting from the charges.

The legislation does not provide that a disciplinary subcommittee may not also adjudicate and determine sanctions for cases in which it performs the functions specified in the statute, nor does it provide for more than one disciplinary subcommittee.

The legislation (SB 291) also provided that on or before December 31, 2011, each health occupations board shall report to the Senate Education, Health and Environmental Affairs Committee and the House Health and Government Operations Committee ways in which separation of the board's disciplinary functions can be further achieved. Our recommendation would be consistent with that legislative goal.

Finally, our recommendation is consistent with the Federation of State Medical Board's 2012 "Elements of a Modern Medical Board." This document (p. 11-12) states that "no member of an investigation

committee shall sit with the Board to hear or adjudicate a matter considered by his or her investigation committee nor shall he or she be counted as part of the Board in determining a quorum for the conduct of business during such a hearing or adjudication.”

**Recommendation 2:**

**\* The Board, under its existing authority should seek to implement and encourage additional informal processes for case resolution.**

While the large majority of cases are resolved prior to charging, it is the cases that go through the charging and adjudicatory process that take up most of the time of the Board, its staff and the OAG and that create the case backlog that currently plagues the Board. The current process does not appear to allow sufficient opportunity for, or to encourage settlement of, cases prior to the drafting of charges.

There are several practices the Board could adopt to encourage earlier settlement. One suggestion would be for the Board to hire or appoint someone whose job it is to track cases and encourage settlement. Such a person might have a background in mediation. Another suggestion is that the Board (or Disciplinary Panel) prior to the CRC meeting and preferably at or shortly after the IRP meeting provide the licensee with a statement stipulating the desired provisions for a Consent Agreement and give the licensee a limited timeframe to respond, e.g., 14-21 days.

**Recommendation 3:**

**\* The Board should have available to it additional access to and time of attorneys within the OAG, both Board counsel and prosecutors, and have the opportunity to provide feedback to supervisory personnel at the OAG about the legal work that is performed by the prosecutors and Board counsel.**

An issue that was raised in our interviews with members of the Board and Board staff as well as in the Sunset Review Report relates to the time it takes for prosecutors to draft charging documents. As noted above, the Sunset Review states that between 2002-2006 and 2007 and 2011, the time taken to have formal charges signed and executed has increased. The Review attributes this in part to an increase in the number of cases referred to the OAG for charging and no corresponding increase in the number of prosecutors assigned to these cases as well as an increase in the number of summary suspensions referred to the OAG (see, supra, p. 8). One or two additional prosecutors devoted to the Board may be necessary to decrease the length of time it takes to draft the charging documents. Currently, the OAG has 4 full-time and 2 part-time attorneys devoted to Board of Physician cases. Greater participation of prosecutors on the front end of a case, i.e., prior to the case being sent to the Board for charging, may also reduce the time required to complete these documents by eliminating the need for further evidence or clarification of investigatory findings.

In addition, we recognize the advantages of having Board counsel physically co-located with the offices of the OAG in terms of supervision and the ability to confer with colleagues regarding legal issues that arise in the representation of health occupation boards. Nevertheless, there also are inefficiencies for Board staff when Board counsel is not readily accessible if staff has questions of a legal nature. Given the benefits that Board counsel may receive from interaction with counsel of other boards and the benefit to the Board of having Board counsel on site, we propose a compromise arrangement in which Board counsel would have an office at the Board of Physician offices and reside in that office two days/week and in the OAG’s office the remainder of the week.

Finally, the Executive Director and Board Chair or other Board officers should meet with representatives of the OAG at least every six months to discuss any delays in processing charging documents; agreed upon time limits for portions of the complaint review process (such as for issuing charges, opinions and declaratory rulings); concerns about insufficient legal guidance for the Board; processes to streamline Board actions; training needs of Board and staff, etc. Moreover, the Executive Director and Board Chair should be given an opportunity by the OAG to provide written comments on the performance of the attorneys who are assigned to the Board. More regular interactions in general would be productive in determining how best to meet the interests of the public.

**Recommendation 4:**

**\* A representative of the allied health professions advisory committee should participate as an ex-officio member in Board disciplinary processes when a member of their profession is the subject of a disciplinary proceeding.**

Current Board operations do not provide for the participation of allied health profession members of the allied health advisory committees in allied health disciplinary matters that are regulated by the Board of Physicians. The expertise of these individuals may be helpful in resolving these cases. We note that the 2011 Sunset Report (p. 36) recommended the following:

Uncodified language should be adopted requiring the board to recommend measures to increase the involvement of allied health advisory committees in complaint resolution and licensee discipline. The board should consider the feasibility and efficacy of (1) allied health advisory committees handling all allied health complaint resolution functions currently handled by board members; or (2) having allied health advisory committee members perform certain complaint resolution functions, such as serving on the Investigative Review Panel to review cases involving allied health professionals. Uncodified language should require that the recommendations be submitted by the board to the Department of Legislative Services in a subsequent follow-up report.

Consistent with our earlier recommendation (#1) we recommend that one allied health professional who sits on the relevant allied health advisory committee participate as an ex-officio member in relevant panel discussions involving charging and/or discipline involving a member of that allied health profession but that the same individual not participate in both the charging and disciplinary process.

**Recommendation 5:**

**\* The Secretary of DHMH in collaboration with the OAG should establish timeframes for Board and attorney actions based on case complexity and whether the case is a matter for summary suspension.**

Both the Board and the OAG should be held accountable for compliance with timeframes for completion of each part of the complaint resolution process. Reasonable timeframes are necessary for both efficiency and fairness to the parties (complainant and licensee). As stated earlier in this report, by statute, the Board is required to dispose of complaints “as expeditiously as possible and, in any event, within 18 months after the complaint was received by the board” [Md. Health Occ. Art., Sec. 14 – 401(k) (1)]. Although the timeline has been interpreted by the courts as not binding, the Board and other actors who have a role in the complaint resolution process should endeavor to reach this outer goal.



The 2009 Task Force on Discipline of Health Care Professionals and Improved Patient Care recommended several timeframes for various components of the complaint resolution process. These timeframes were more generous than the statutory maximum and included the following: 1) time from receipt of complaint to a decision to charge (18 months); 2) time to issue charges after a decision to charge (90 days); 3) time from issuance of charges to hearing on charges (90 days); and 4) time from the later of an ALJ decision or Board hearing to final decision of the Board (90 days). The Task Force further recommended that the Maryland General Assembly authorize the Secretary of DHMH to issue guidelines to the boards relating to these timeframes. This would establish uniformity across the boards and provide a basis for monitoring board timeliness of action. Senate Bill 291(2010) [see Health Occ. Art., Sec. 1-608] implemented this recommendation in large part stating that:

- (A) The Secretary shall monitor the timeliness of complaint resolution for each health occupations board.
- (B) (1) On or before October 1, 2012, the Secretary shall establish goals for the timeliness of complaint resolution for all of the boards, a group of boards, or a specific board, including:
  - (i) After a complaint is filed with a board, a goal for the length of time a board has to complete an investigation and determine whether to bring charges;
  - (ii) After a board makes a decision to charge, a goal for the length of time a board has to issue charges;
  - (iii) After a board issues charges, a goal for the length of time a board has to schedule a hearing; and
  - (iv) After the date of an opinion from the Office of Administrative Hearings or the final day of any hearing, a goal for the length of time a board has to issue a final decision.

From the perspective of the public, it is important that the Board complete the complaint resolution process in a timely manner. The timeframes should be linked to the type and complexity of the cases, i.e. the standard of care cases involving multiple records, overutilization and self-referral cases versus standard of care cases involving one medical record; failing to provide a medical record; sexual impropriety cases; CDS/overprescribing cases; and unprofessional conduct cases involving threatening behavior or violence towards staff or patients. We therefore propose that the Secretary adopt the following timelines as the outermost times for each section of the process, but that the Secretary and OAG appoint a committee, including stakeholders, to establish shorter timeframes for less complicated cases:

- (a) Time from filing of complaint to completion of investigation and determination of whether to bring charges – 8 months.
- (b) Time from board decision to charge to prosecutor completion of charging document – 75 days.
- (c) Time from prosecutor issuing charging document to date of hearing by ALJ – 60 days.
- (d) Time from completion of hearing by ALJ to ALJ issuance of an opinion – 60 days.
- (e) Time from issuance of ALJ opinion to final decision by the Board – 60 days.
- (f) Time from final Board decision to completion of written decision – 45 days.

The committee should also establish separate shorter timeframes for summary suspension cases. According to the 2011 Sunset Review Report, the number of summary suspensions “voted by the board has increased significantly from just 8 in calendar 2009 to 27 in calendar 2010.” We also heard in our background interviews that summary suspensions can take up to 250 days which is excessively long.

**Moreover, we expect that the maximum timeframes should be reduced over a two to three-year period as changes recommended in this report are implemented with a goal of completing the**

**majority of the cases within one year.** We would expect that such discussions would include stakeholders. The Board and OAG should report to the Maryland General Assembly by October 1, 2014 with further recommendations to reduce the maximum timeframes listed above.

It is absolutely essential that the Executive Director establish a process to monitor each of the above listed complaint resolution steps and create an “exceptions report” showing where a deadline is approaching or passed for any item, reasons for any delays, and an action plan for each item. As a matter of “quality improvement,” the Board should examine cases that take longer than the specified timelines to determine the reason for any delay. This would also be consistent with Health Occ. Art., Sec. 14 -401 (k) (2) which requires that if “the board is unable to resolve a complaint within one year, it must include in the record of the complaint a detailed explanation of the reason for the delay.” (2011 Sunset Report, p. 50).

**Recommendation 6:**

**\* The Board should finalize and implement sanctioning guidelines for physicians and allied health professionals as soon as possible.**

The Board has proposed regulatory changes to the Code of Maryland Regulations which include sanctioning guidelines for physicians. OAG representatives and Board staff developed the regulations on April 25, 2012, based on their knowledge of past actions. The proposed changes to the regulations were published in the Maryland Register on June 1, 2012 and were made available for public comment through July 2, 2012. The Board received several comments and we urge the Board to seriously consider those comments and make any revisions it believes are necessary to the guidelines. Consistent with statutory requirements [(Health Occ. Art., Sec. 1-606], the Board should implement use of the guidelines as soon as they have been finalized and promulgated. The guidelines should provide the Board and licensees with a general and consistent framework for penalties, but also with sufficient flexibility to take into account the specific circumstances of each case. Guidelines ensure transparency for licensees and the public and accountability for the Board’s actions. Also, should the Board and the Maryland General Assembly adopt our recommendation to divide the Board into two panels, the sanctioning guidelines will be important in order to ensure that each panel is treating like cases similarly.

In addition to implementing the proposed guidelines for physicians, we recommend that once the Board’s guidelines for allied health professionals under its jurisdiction are adopted, the guidelines should be implemented to ensure that allied health professions are fairly sanctioned.

**Recommendation 7:**

**The Board should acquire or develop the expertise to review and evaluate fraud and self-referral cases.**

The incidence of fraud and self-referral is a sanctionable action for physicians under the Health Occupations Art., Sec. 1-302, which provides that:

“Except as provided in subsection (d) of this section, a health care practitioner may not refer a patient, or direct an employee of or person under contract with the health practitioner to refer a patient to a health care entity:

- (1) In which the health care practitioner or the practitioner in combination with the practitioner’s immediate family owns a beneficial interest;

- (2) In which the practitioner's immediate family owns a beneficial interest or 3 percent or greater; or
- (3) With which the health care practitioner, the practitioner's immediate family, or the practitioner in combination with the practitioner's immediate family has a compensation arrangement."

The law also has several exceptions. The Maryland self-referral law itself also contains the following language [Health Occ. Art., Sec.1-304(b)]: "A health care practitioner who knows or should have known of the practitioner's failure to comply with the provisions of this section shall be subject to disciplinary action by the appropriate licensing board."

It was not clear in interviews we conducted that the Board possessed the expertise either through its staff or Board members to adequately investigate complaints of fraud or self-referral, especially cases involving complex financial matters. Furthermore Chapter 539 of the 2007 Laws of Maryland provided that "on or before October 1, 2007, the Dept. of Health and Mental Hygiene and the Office of the Attorney General shall:

- (1) Review the process for the investigation of self-referral cases by the health occupations boards;
- (2) Recommend a revised investigative process for self-referral cases that includes the determination of investigative resources for the health occupations board in the investigation of self-referral cases; and
- (3) Report to the Governor and, in accordance with Sec.2-1246 of the State Government Article, to the Senate Education, Health and Environmental Affairs Committee and the House Health and Government Operations Committee on their findings, recommendations, and any legislative or regulatory changes necessary to implement any recommended changes.

Former Secretary of DHMH John Colmers reported to Governor O'Malley, Senator Joan Carter Conway, Chair, Education, Health and Environmental Affairs Committee, and Delegate Peter Hammen, Chair, Health and Government Operations Committee, in a letter dated October 29, 2007. In that letter, former Sec. Colmers stated that "Many states that have self-referral statutes house enforcement within the administrative organization that oversees the activities of the licensing boards. Maryland has no such entity. The investigators in Maryland are trained to evaluate violations of scope of practice and not the economic and accounting violations that are part of self-referral." The letter went on to say:

To date, the Maryland Board of Physicians has prosecuted one case and issued two declaratory rulings construing Maryland's Self Referral Law. One of those declaratory rulings is currently on appeal. . . . The Board of Physicians currently has one complaint under investigation and complaints involving eight medical practices on hold pending the outcome of the appeal of the Board's declaratory ruling. If the courts affirm the declaratory ruling, the Board will have the responsibility to enforce that ruling as well as complete the investigation of the complaints currently on hold. The Board also anticipates that, once the declaratory ruling is final, it will receive many more complaints."

Subsequent to the letter, on January 24, 2011, the Maryland Court of Appeals affirmed the Boards' declaratory ruling on MRI scans (see Potomac Valley Orthopedic Associates, et al., v. Maryland State Board of Physicians). In the 2007 letter, former Sec. Colmers went on to suggest that the Board of Physicians could through its revenues from licensing fees fund two positions to support the investigation and prosecution of these cases. While this is one possible solution to the problem of inadequate expertise and resources currently possessed by the Board staff, an alternative recommendation is that

the Board refer these complaints to a consultant or other governmental agency with knowledge in this area for investigation and an opinion as to whether the actions of the licensee violated relevant disciplinary standards.

**Recommendation 8:**

**Board counsel and/or prosecutors should collaborate with Board staff to develop templates for investigators to use in gathering evidence.**

The Board counsel and OAG prosecutors should collaborate with the Board staff to develop or enhance templates containing the type of information that Board staff should collect for each disciplinary ground. Once a decision is made by a Disciplinary Panel to proceed with further investigation and work up of the case for potential charging, the prosecutors and investigators should discuss any specific information needed for legal sufficiency. This will better ensure that Board staff investigators provide sufficient evidentiary information to the Board and OAG prosecutors. Templates will better enable prosecutors to have all the evidentiary information they need to write the charging document when a case goes forward for charging and avoid the need for sending the case back to the staff to gather additional information. Potential frameworks for templates (based on ones used in Kentucky) were provided to Board staff for consideration. An illustration follows:

**For False Statements on Applications:**

- Elements of the Violation: Knowingly made or presented, or caused to be made or presented any false, fraudulent, or forged statement, writing certificate, diploma, or other thing in connection with an application for a license or permit.
- Evidentiary Considerations:
  - The document containing the false/ forged statement, with particular attention to the statement and the date of the document was completed.
  - Evidence showing that the statement, etc. is false or forged.
  - Evidence of the earliest date that the licensee would have known the true information.

**Recommendation 9:**

**\* Other than for exceptional cases, the Maryland General Assembly should authorize the Board to use only one peer reviewer (in addition to the Board's internal medical reviewer) in standard of care cases.**

As indicated above, by statute [Health Occ. Art., Sec. 14-401(e)] the Board must obtain two peer reviews for standard of care violations [Health Occ. Art., Sec. 14-404 (22)]. Based on our interviews, it appears that the two peer reviewers are in agreement in the large majority of cases. Many of the individuals we interviewed also agreed that only one consultant should be required for all cases, but with allowances for special issues (such as for complex medical cases or where additional specialized expertise is required). This would save time and costs as well as decrease the exhaustion of experts in the consultant pool. Moreover, the in-house medical director provides some consistency in the way standard of care complaints are treated and serves as another reviewer. With a second in-house medical director, he or she could be called upon for added review.

**Recommendation 10:**

**The OAH should designate a smaller pool of Administrative Law Judges (ALJs) with training in medical matters to hear Board cases and the Board should assist in the training of those ALJs.**

Based on interviews (and consistent with the recommendation from the 2005 Sunset Review Report), we learned that Administrative Law Judges (ALJs) assigned to Board cases may not be sufficiently familiar with the complex medical facts that surround most Board of Physician cases which go to an administrative hearing. As a result, Board prosecutors must spend a significant amount of time during the hearing explaining “the intricacies of medical practice related to a particular case” to the administrative law judge. Thus, we recommend that the OAH designate a smaller number of ALJs to hear Board of Physician cases so that they can develop sufficient expertise in medical matters to enhance their understanding of the cases that come before them. Consistent with the 2011 Sunset Review Report (p. 55), the Board should also “provide training at least annually to OAH personnel (designated to hear Board of Physician cases) on medical terminology, medical ethics, and to the extent practicable, descriptions of basic medical and surgical procedures currently in use.” The OAH also indicated a desire for additional training, which the former Executive Director had agreed to provide annually (but which was not consistently provided). These recommendations are also consistent with 2007 Laws of Maryland, Chapter 539.



#### **IV. MARYLAND BOARD OF PHYSICIANS – PURPOSE, COMPOSITION, AND DUTIES**

This section of the report provides a brief review of the composition of the Board, its mission, duties and other related matters and sets forth specific recommendations to ensure that the Board can fully carry out its duties.

##### **A. Current Status**

By statute the Board consists of 21 members appointed by the Governor with the advice of the Secretary [Health Occ. Art., Sec. 14-202]. The members include 12 practicing physicians (including one doctor of osteopathy); 1 representative of the Department of Health and Mental Hygiene (DHMH); 1 certified physician assistant; 1 practicing physician with a full-time faculty appointment at an academic medical institution in this State; 5 consumer members; and 1 public member knowledgeable in risk management or quality assurance matters. No more than 2 of the physicians may be from the same medical specialty. The term of office is 4 years, with staggered appointments and with a limit of 2 consecutive full-terms (plus any period a member serves until a successor is appointed). The staggered terms enables the Board to have a sufficient number of members with fairly extensive experience and institutional memory. Except for the change enacted by HB 824 (Chapter 681, 2012 Laws of Maryland) effective June 1, 2012, which requires the Governor to appoint the Chair (with a 2 year term of office), the officers are to be elected by the Board members [Health Occ. Art., Sec 14-202]. All licensees or certificate holders are to be notified of any Board vacancies, including through use of electronic mail or notice on the Board's website [Health Occ. Art., Sec. 1-215]. A member may be removed from the Board: (1) by the Secretary, on the recommendation of the Board, for neglect of duty, misconduct, malfeasance or misfeasance in office; (2) by the Governor, upon the recommendation of the Secretary, for absence from two successive Board meetings without adequate reason; or (3) by the Governor for incompetence or misconduct [Health Occ. Art., Sec 14-202].

As of June 30, 2012, the terms of six members expired, including the then Chair (Paul Elder, MD), two consumer members, two other physicians, and the Department's representative (also a physician). Five of these six members served for one term, but the sixth (a physician) served since 2003. The law requires that to the extent practicable, the membership shall reasonably reflect the geographic, racial, ethnic, cultural, and gender diversity of the State [Health Occ. Art., Sec. 1-214]. Based on the composition of the Board prior to June 30, 2012, the Board generally reflected the licensee population, with 8 females, 8 minorities (4 African Americans, 3 Hispanic/Asians and 1 Indian representative), and 3 members from rural areas. On July 3, 2012, Governor Martin O'Malley announced the appointment of a new chair of the Board, Andrea Mathis, MD. The Governor also announced 3 other new Board members and the reappointment of 2 current Board members. The Board remains reflective of the licensee population, now with 9 females, 8 minorities (5 African Americans, 3 Hispanic/Asians and 1 other unidentified minority), and 3 members from rural areas of the State.

A number of sections of the Health-Occupations Article, in addition to the general powers which are set forth in Health Occ. Art., Sec 14-205, provide for various powers and duties of the Board. These powers generally relate to adopting rules, regulations and orders; licensing; investigations; judicial powers (such as subpoenas, entry onto premises); profiles of licensees; contracting for services; submitting annual reports; hiring of staff; setting reasonable fees for licensing and other services; and creation of specified advisory committees whose members are appointed by the Board. The statutory advisory committees include the following: (1) physician assistants, (2) radiographers, radiation therapists, nuclear medicine

technologists, and radiologist assistants, (3) respiratory care professionals, (4) polysomnography professionals, (5) athletic trainers, and (6) perfusionists. Many other state medical boards regulate these same or similar allied health professions based on data from the Federation of State Medical Boards.

The statute also provides for various powers, and limits on powers, of the Secretary regarding the health occupation boards in general. For instance, the Health Occupations Article provides the following general powers of the Secretary over health occupation boards:

Section 1-203:

- (a) The power of the Secretary over plans, proposals, and projects of units in the Department does not include the power to disapprove or modify any decision or determination that a board or commission established under this article makes under authority delegated by law to the Board or commission.
- (b) The power of the Secretary to transfer staff or functions of units in the department does not apply to any staff of a board or commission, established under this article, or to any functions that pertain to licensing, disciplinary, or enforcement authority, or to any other authority specifically delegated by law to a board or commission.

Section 1-217: Requires the secretary to confirm the appointment of each executive director.

It is important to note that the Secretary may not be involved in disciplinary matters of the health occupations boards and based on our interviews with Secretary Joshua M. Sharfstein, MD, he fully recognizes and supports this limit on his authority.

Other powers of the Secretary specifically over the Board of Physicians are set forth in Title 14, Health Occupations Article (Physicians). Section 14-205 provides that the Secretary may employ a staff for the Board in accordance with the State budget. The Secretary may designate one of the staff as an executive director. Under that authority, Secretary Sharfstein appointed Ms. Carole Catalfo, Esq. as the new Executive Director of the Board of Physicians in February 2012.

**It should be noted that Maryland statutory law does not provide a “statement of policy” to guide the actions of the Maryland Board of Physicians (nor any of the health-occupations boards) in their overarching responsibility to protect the public. Further, the law does not clearly set forth the Board’s responsibility to oversee staff operations, which may have contributed to a general perception among Board members that they have no oversight role of the staff.** With respect to the Board’s purpose, the Board’s website does provide the following statement: “The mission of the Board of Physicians is to assure quality health care in Maryland, through the efficient licensure and effective discipline of health providers under its jurisdiction, by protecting and educating the clients/consumers and stakeholders, with ongoing development and enforcement of the Maryland Medical Practice Act.”

Regarding Board member training, the Health Occ. Art., Sec. 1-216 requires the health occupations boards to develop collaboratively a training process and materials for new board members that includes training in cultural competency. Each new health occupation board member is offered an opportunity to participate in a general orientation training provided by the Department of Health and Mental Hygiene, in conjunction with the Office of the Attorney General (OAG). The orientation is offered only annually and each attendee is provided with a general training manual. The former Executive Director provided new Board members with what some Board members described as a fairly cursory review of a



binder providing more detail about the Board of Physicians, but the discussion focused primarily on the required time commitment of members. From interviews with newer Board members, the training regarding matters specific to the Board of Physicians was either absent or insufficient. Some Board and staff members also attend annual meetings of the Federation of State Medical Boards to learn about current topics, discuss board structure and functions, and network with colleagues from other states to seek their insights.

To be adequately prepared for meetings, Board members are literally asked to review thousands of pages of materials relating to complaint investigations. The 2011 Sunset Report (p.67) noted that “compiling board books diverts staff from assigned duties and represents an additional drain on resources as board books must be sent overnight to board members.” This process entailed an inefficient use of resources and attributed to delays in staff and Board actions. Recently, members were provided with electronic notepads loaded with materials for their review prior to each Board meeting. This has reduced staff processing time, but added some complexities for Board members in accessing materials and their notes when the item comes up for discussion at a meeting. These minor technicalities can be ironed out as use of the new system evolves. In the longer-term, it should result in more efficient use of time and resources for both Board members and staff.

## **B. Issues/Concerns Raised**

In interviews with Board members and staff, a number of themes emerged regarding the Board’s operations, particularly the lack of clarity regarding the role of Board members, the need for more training, the time commitment necessary to serve on the Board, and the lack of information that staff previously provided to the Board. Our observations of full Board, IRP and CRC meetings confirmed many of the concerns that were expressed. Major comments and observations follow:

### **1. Size and Composition of Board**

- I. The size of the Board can be unwieldy at times when so many members want to participate in discussions on the many matters that come before the Board. Dividing the Board into two panels to act on disciplinary matters may be helpful in this regard.
- II. There is a lack of representation of certain specialty physicians on the Board where their particular expertise could be helpful.
- III. As members change, there is a need to ensure that new Board members are well -qualified. They should have clear expectations of responsibilities and of the amount of work required for Board service. It is also important to ensure that institutional memory on Board actions be preserved.
- IV. Representation on Board committees from each academic health center (Johns Hopkins University School of Medicine and the University of Maryland School of Medicine) and from allied health professions would help to provide more expertise.

### **2. Expectations of Board Members and Training**

- I. A number of Board members stated that orientation and ongoing training is insufficient, particularly regarding their role, duties, and limitations (similarly cited in 2011 Sunset Report p. 70).

- II. Some Board members were surprised that the Board had failed to comply with certain requirements of the law, such as the requirement for sanctioning regulations or to update regulations as practices changed. They indicated that they had not been adequately informed by staff regarding the Board's need to address these matters.

### **3. Board Functions**

- I. The full Board literally has no time to discuss or seek expertise on major policy matters, such as scope of practice issues, use of telemedicine, how to evaluate physicians prescribing large amounts of pain medication, or how best to inform or involve licensees and the public about the Board processes and actions.
- II. The Board lacks the ability to control use of its own funds, with monies transferred to the General Fund to address the State's deficit.
- III. The law does not specify the Board's role in staff oversight, nor in holding the Executive Director responsible for proper management of the agency, budget and oversight of compliance with requirements of the law.
- IV. Some Board members indicated that they had no idea of the extent of the case backlogs or of many of the problems cited in the 2011 Sunset Report. One member observed that the prior Executive Director indicated that a "firewall" must be maintained between the Board and staff, which resulted in the Board being poorly informed about the backlog of investigations and problems identified in the 2011 Sunset Report.

### **C. Recommendations**

In view of the foregoing observations, our recommendations in this section focus on setting forth a statement of policy for the Board; modifying the size and composition of the Board; enhancing training efforts for Board members; and more clearly delineating the Board's powers. The recommendations are primarily intended to support more streamlined operations and better prepare the Board to more timely meet their responsibilities to protect the public. Without these types of fundamental process changes, we believe that findings in the 2011 Sunset Report could be repeated in future years.

**Key recommendations are noted with an \* (asterisk).**

#### **Recommendation 11:**

**The Maryland General Assembly should adopt a "statement of policy" guiding the actions of the Board of Physicians.**

We recommend that the legislature set forth a clear statement of policy to guide the actions of the Board and clarify the Board's overarching responsibility to protect the public. The Federation of State Medical Boards recommends that a statement of policy should contain the following concepts:

- A. The practice of medicine is a privilege granted by the people acting through their elected representatives.
- B. In the interests of public health, safety and welfare, and to protect the public from the unprofessional, improper, incompetent, unlawful, fraudulent and/or deceptive practice of medicine, it is necessary to provide laws and regulations to govern the granting and subsequent use of the privilege to practice medicine.

- C. The primary responsibility and obligation of the state medical board is to protect the public through licensing, regulation and education.

The Maryland General Assembly may also want to consider adopting a general “statement of policy” guiding the actions of all health occupations boards regarding their paramount duty of protecting the public.

**Recommendation 12:**

**\* The Maryland General Assembly should increase the Board size from 21 to 22 members, including making a change in Board composition, and divide disciplinary matters between two panels.**

The 21 member size of the Maryland Board of Physicians is among the largest in the country. Approximately 18 state medical boards have 15 or more board members, but less than 5 medical boards have 20 or more board members (based on information from the Federation of State Medical Boards). Our initial inclination was to recommend a reduction in the number of Board members. **Nevertheless, we believe that it would be more efficient and provide greater due process to increase the Board size from 21 to 22 members and divide much of the Board’s work between two panels of 11 members each (per recommendation #1).** Each panel would have the authority to make a final determination in a case. Each 11-member panel would generally be parallel in composition and be of a reasonable size for decision making. The size of each panel would be comparable to that of many of the smaller medical boards across the country, since approximately 20 states have medical boards consisting of 11 or fewer members.

**In sum, we therefore recommend that the Board be increased from 21 to 22 members, with the following changes in the composition of the Board:**

- Increase from 1 to 2 the number of physician assistants on the Board;
- Increase from 1 to 2 the number of practicing licensed physicians on the Board having a full-time faculty appointment at an academic medical institution in this State, with one from Johns Hopkins University School of Medicine and one from the University of Maryland School of Medicine;
- Reduce from 12 to 11 the number of required remaining licensed practicing physicians on the Board;
- Eliminate the requirement that there be 1 doctor of osteopathy on the Board (note--of the licensed physicians in Maryland, only about 3% identify themselves as being a “Doctor of Osteopathic Medicine”);
- In lieu of 5 consumer members and 1 public member knowledgeable in risk management or quality assurance matters, require that there be 4 consumer members and 2 public members knowledgeable in risk management or quality assurance (this maintains 6 public members on the Board, but adds expertise).

These recommendations require revisions to Health Occ. Art., Sec. 14-202.

The Board should advise the Governor, Secretary, and Executive Director of any particular expertise desirable for new Board members as candidates are sought to fill vacancies. For instance, some Board members indicated that an expert in pain management could be helpful to the Board (and one was just appointed to the Board on July 3, 2012). Also, the Federation of State Medical Boards has a model policy for treatment of pain issues, which could be helpful in guiding Board actions. There is no way that all medical specialties can be represented on the Board, but statute authorizes the Board to access specialized expertise, as needed [Health Occ. Art. Sec. 14-401]. Since the need for specialized expertise

is dynamic, changing as the practice of medicine changes, a particular expertise should not be mandated, but rather considered as part of the appointments process to maintain sufficient flexibility in meeting Board needs.

Recruitment of Board members should be wide ranging to ensure that physician and allied health members represent well-respected practitioners and diversity in composition of the Board. Efforts should be increased to encourage more licensees and consumers to apply, with the Board and staff actively encouraging all licensees and all the medical associations in the state to recommend high quality, diverse candidates from across Maryland. DHMH should ensure a strong internal process for vetting candidates to continue strengthening diversity and assure highly regarded candidates who fully appreciate the major time commitment and obligations they must fulfill. The Board and DHMH should prepare a written description of responsibilities and expectations of Board members. This should be fully discussed with candidates during the vetting process before any candidates are recommended to the Governor for appointment to the Board.

**Recommendation 13:**

**The Board should require orientation training for new members and ongoing training for all Board members.**

**Board staff, DHMH and the Office of the Attorney General (OAG) should enhance the current annual orientation training offered to new members of all health occupation boards. More in-depth, tailored training should be provided annually to members of the Board of Physicians, including a review of responsibilities and expectations of members; the roles of staff, counsel, prosecutors, and the Office of Administrative Hearings; review of pertinent Maryland law, regulations, and parliamentary procedures; and any topical area in which more expertise could better inform the Board in carrying out its duties.**

We understand that Board staff is to implement more comprehensive training for all new and returning Board members beginning in August, 2012 (in compliance with recommendations 29 and 30 of the 2011 Sunset Report). An outline of the proposed training was made available to us. New Board members should be required to participate in general orientation training, which DHMH and the OAG provide annually. Moreover, all Board members should participate in annual training tailored to the Board of Physicians, which can be offered in-person and electronically for any member who may not be able to attend the training. Training is essential to ensure that each member fully comprehends his or her role and duties, those of staff and representatives of the OAG and OAH, and the extent of and limitations on the powers of the Board. Training in subject matter expertise (such as cultural competency, pain management, etc.) by outside experts via webinars or in-person training also should be made available to Board members and staff as needed. Members should rotate participation in conferences offered by the Federation of State Medical Boards and other recognized entities [See similar recommendations in 2011 Sunset Report p. 70].

**Recommendation 14:**

**\* The Maryland General Assembly should consolidate and more clearly delineate the duties and powers of the Board.**

State medical boards must be properly organized and appropriately empowered if they are to effectively discharge their responsibilities of licensing, regulation, and education to the public. We therefore recommend that the Maryland General Assembly should set forth the general powers and duties of the Board in a single section in the Health-Occupations Article to clarify and better delineate the Board's responsibilities. Below is a list of the types of powers and duties recommended for state medical boards by the Federation of State Medical Boards. All listed citations are to the Health-Occupations Article and reflect only some of the related statutory provisions which are spread throughout various sections of the Article. Note that where no citation is listed, the statute appears to be silent on that power or duty.

1. Enforce the statute [Sec. 14-205];
2. Adopt rules and regulations to effect the provisions of law and to fulfill Board duties, including maintaining policies that reflect current practice [Sec. 14-205];
3. Establish policies for Board operations;
4. Oversee licensing requirements, approve issuance and renewals of licenses and maintain secure and complete records [various sections, such as, Sec. 1-219, 1-601 and Sec. 14-205, 14-307 and 14-313];
5. Review and investigate complaints, including acknowledging receipt of complaints and informing the complainants of final disposition [Sec. 1-307 and Sec. 14-401 and 14-205];
6. Establish a mechanism for the identification and monitoring of treatment of licensees dependent on alcohol and other addictive substances and a mechanism for licensees to voluntarily self-report [Sec. 14-401 and 14-402];
7. Develop methods to identify incompetent licensees who fail to meet acceptable standards of care **and develop and implement methods to assess and improve licensee practices;**
8. Develop methods to ensure the ongoing competence of licensees [Sec. 14-316 and various duties of the advisory committees];
9. Conduct hearings and adjudicate matters within its jurisdiction and issue final decisions [Sec. 1-602, and Sec. 14-405 and 14-406];
10. Discipline licensees and report on all disciplinary actions, license denials and license surrenders [Sec. 1-307 and 1-602 and Sec. 14-404, 14-411, and 14-411.1];
11. Institute proceedings in courts of jurisdiction to enforce orders and statutory provisions;
12. Oversee Board staff to ensure efficient and effective operations [Sec. 14-204 only references the Secretary's power to employ staff];
13. Establish appropriate fees and charges and provide reasonable notice of changes. Board fees should be adequate to fund the effective regulation of the practice of medicine and reasonably reflect the costs to regulate the pertinent field of practice, such as physicians, physician assistants, etc. [Sec. 1-205 and 1-209 and 14-207];
14. In conjunction with DHMH, recommend changes in statute or proposed legislation, which benefit the health, safety and welfare of the public;
15. Provide ongoing education and training for Board members to assure they can competently discharge their duties;
16. Direct educational outreach to and communicate with licensees, students and the public;
17. Develop and adopt a budget reflecting revenues, supporting the costs associated with each health care field regulated, and allocations for reasonable reserves;

18. Develop and approve an annual report and other required reports for submission to the Secretary, Governor, Maryland General Assembly, and public [Sec. 14-205];
19. Approve contracts, as needed and within budgetary limits [Sec.14-401];
20. Appoint standing and ad hoc committees from among its members, such as an administrative committee to oversee and guide Board staff operations and ad hoc committees dealing with special topics, such as recommendations from Allied Health Advisory Committees [see Sunset Report, p. 72]; and
21. Delegate to the Executive Director, the Board's authority to discharge certain duties, but hold the person accountable to the Board.

## **V. BOARD STAFF FUNCTIONS AND EFFECTIVE OVERSIGHT OF STAFF**

This section of the report provides a brief background about the administrative functions of the staff which supports the Board of Physicians; identifies staff changes that have been instituted since the new Executive Director started in February 2012 (following the issuance of the 2011 Sunset Review Report); and sets forth recommendations relating to the need for further administrative changes. The overall intent is to continue strengthening the functioning of the Board and avoid a repeat of many of the root causes of the findings in the 2011 Sunset Report.

### **A. Background and Current Process**

Any medical board must oversee and assess its administrative staff to ensure effective operations and efficient use of resources. A number of the criticisms raised in the 2011 Sunset Report are based on a lack of clearly defined responsibility of the Board for oversight of the staff and an apparent lack of sufficient communications with the Board by the former staff management. From the 2011 Sunset Report and our observations, it appears that most Board staff members were adequately performing their job duties, but the Board was not being sufficiently informed of the failure to meet a number of requirements in the law or of the extent of the backlog of investigations. Similarly, licensees, DHMH, the Maryland General Assembly, and the public were inadequately informed about Board processes and staff problems in meeting responsibilities. As noted earlier, the Board's role regarding staff oversight is not clearly delineated in law or regulations.

The former Executive Director, according to some Board members, maintained a "firewall" of separation between the Board and staff, not allowing the Board to intrude in staff operations. As a result, the Board did not play a role in the oversight of the staff. We noted a number of administrative problems which arose under the watch of the former staff management. For instance, there were no job descriptions/qualifications available for staff positions and evaluations had not been completed for several years, making it difficult to assess staffing needs and staff performance. According to staff, the Board has not been involved in development of the budget for the Board (the Board's budget is about \$8.8 million for FY 13, including \$1.3 million for OAG attorney time). Board members have not been involved in reviewing the allocation of costs across the various types of licensees regulated by the Board to determine the reasonableness of fees and charges. The licensing process itself is a 100% paper process, which fails to accommodate quick turnaround of information and affords many opportunities for errors. The investigations were not adequately tracked so there was no way for the Board to discern if investigators and prosecutors were current with their caseloads, where delays or problems were arising, or even the extent of backlogs. The staff's systems (both manual and automated) failed to accurately capture and report data needed to track workload or output. Further, the website for the Board was sorely lacking in content and difficult to navigate, with little transparency (also identified in Recommendation #26, 2011 Sunset Report). The agency's IT infrastructure, dating back to the mid to late 1990's, was never developed for "tracking" purposes according to staff; only for purposes of "investigations." The staff failed to adequately establish processes to gather and analyze data, which would allow it to anticipate and track delays in investigations and other required actions regarding cases before the Board. Our interviews disclosed that there was a lack of communication among Board staff, Board counsel and the prosecutors with no one being able to adequately identify where the bottlenecks had been occurring. Moreover, the 2011 Sunset Review Report (p. 93) noted that the Board fails to comply with several statutory requirements regarding: (1) complaint investigation files; (2) provision of contact information on the Board website regarding medical malpractice information; (3) obtaining peer

review reports; (4) public disclosure of board filing of charges; (5) compliance with the Open Meetings Act; and (6) failure to adopt regulations as required by law. It is difficult to understand how the staff and representatives of the OAG failed to adequately address these problems with the Board. These issues are illustrative of the many administrative problems that plagued the agency during the period that the 2011 Sunset Review Report was conducted.

**Fortunately, many changes are already in process.** First, the Board recently appointed an ad hoc “Dashboard Committee” to offer input into resolving the recommendations in the 2011 Sunset Report. The Committee reviews monthly updates of actions to address the recommendations. Further, the committee is to discuss and recommend actions on other issues raised by the staff or Board members. Topics to date have included Board training, agendas, meeting procedures, internal staff workgroups, and the staff organizational chart, etc.

Secondly, another major positive change was the hiring of a new Executive Director, Ms. Carole Catalfo, who started in February 2012. Under her leadership, a significant number of administrative changes already have been implemented or are underway, which should address some of the administrative problems at the root of the findings in the 2011 Sunset Report. Among the changes at the agency are the following:

- Ms. Catalfo reported at the June 2012 Board meeting that job descriptions (MS 22s) had been created for all staff positions and all staff performance evaluations for FY 2012 had been submitted prior to the deadline of June 30, 2012. Copies of the job descriptions were provided to us.
- Tailored training for new and returning Board members is scheduled for August 2012. At the June Board meeting, the staff also reported to the Board regarding the type of training that is to be provided by the staff and OAG representatives, including, a review of the Open Meetings Act, parliamentary procedures, “roadmaps” for all staff divisions, and Board and staff roles in protecting the public. The training is to be recorded for those who cannot attend in person.
- The Investigations Unit has been restructured into a Compliance Unit to improve oversight of investigations and caseloads. A staff team has been assigned to help resolve many of the older cases. The Licensing and Administrative Services Units are pending reorganization.
- The freeze exemptions have been approved and the positions have been submitted for approval to post the three new positions authorized in the FY 2013 budget (Licensure Administrative Specialist III, Administrative Officer II, and Compliance Analyst Investigator).
- The Board website has been improved to more easily navigate the site and locate desired information. More improvements are still needed as well as more content to better inform licensees and the public about the Board and its functions and processes.
- The staff is reviewing the current fee structure for physicians and allied health practitioners, including the fees for the rehabilitation program. Staff is to prepare an analysis of fees imposed in Maryland versus other nearby states.
- An internal group is determining where regulations are inconsistent with practice to initiate a process to revise the pertinent regulations.
- The staff is now reporting general monthly performance data on licenses, complaints, and disciplinary actions as part of StateStat, which can be found at: <http://dhmh.maryland.gov/statestat/SitePages/Home.aspx> (see Health Boards).
- The staff is updating status codes which have been added to the existing tracking system to improve data collection and tracking of complaint resolution processes. This should enable staff to stay current on investigations.



- Lastly, the staff has set out specifications for a new IT software system and is assessing resources to support the anticipated expenditures. This likely will be spread over a several year period. Timing for the new system is unknown; however, the Executive Director is working with DHMH to determine how best to proceed with the procurement of a new system supporting licensure and complaint investigation/resolution.

## **B. Issues and Concerns Raised:**

A number of concerns in the 2011 Sunset Review Report appear to generally relate to a lack of understanding by the Board of the need to oversee the staff function of the Board. Themes that emerged in our interviews follow:

### **1. Investigatory Function**

- I. Investigators need more formal training and/or experience and more effective skills in conducting investigations and communicating information to the Board.
- II. When investigators left the agency, their cases were reassigned but became low priorities for other investigators; some cases fell through the cracks and investigations were not sufficiently tracked by management, which contributed to the backlogs.
- III. A high attrition rate helped drive the backlogs and lost cases.

### **2. Licensing Function**

- I. The licensing process is still a 100% paper process which is time consuming and an inefficient use of resources for licensees and staff.

### **3. Information Systems**

- I. The automated systems used by the agency are inadequate to support database needs and tracking.
- II. The existing system is useful only for investigation, but not tracking.
- III. Action is needed to ensure that paper and online data are consistent.

### **4. Consumer Outreach**

- I. More proactive education is needed to help physicians avoid problems, including more communications with the physician community.
- II. The public should be better informed about the regulatory process.

### **5. General Oversight of Agency**

- I. The Board does not have mechanisms in place to oversee staff operations.
- II. We did note that more than \$5 million of the Board's fund balance was re-directed to the State general fund to offset a significant state fiscal shortfall. Ideally, this re-direction should be discouraged since the funds were derived for dedicated purposes. (Note: This action was parallel to fund balance transfers across State government to resolve the short-term State deficit without doing significant harm to most programs or services).

### **C. Recommendations**

These recommendations focus on continuing to strengthen staff functions which will result in resolving the root cause of many of the problems cited in the 2011 Sunset Report.

**Key recommendations are noted with an \*(asterisk).**

#### **Recommendation 15:**

**\* The Board should establish committees to assure adequate oversight of agency operations.**

The Board should establish standing or ad hoc committees to oversee and report to the Board on matters relating to the Board's administrative/staff functions and on special issues. For instance, the Board recently established an ad hoc "Dashboard Committee" which now meets monthly with the Executive Director to review and track progress on the 2011 Sunset Report recommendations to ensure timely resolution. It would be helpful for a monthly "Action Report" showing the current status of each item to be posted on the Board's website to enhance transparency. It should be noted that although our report did not focus on each recommendation in the 2011 Sunset Report, the new Executive Director has submitted the status of actions as of July 19, 2012 which is included in **Appendix C**.

Further, an ad hoc "Administrative Committee" should be appointed by the Board to help guide and oversee staff operations, such as the development of the Board's proposed budget; allocation of costs to align fees with expenditures and assure reasonableness of fees and charges; upgrade and procurement of new IT systems; a strategic and fiscal plan, general staff functions, etc. The Administrative Committee should use the budget as a basis to assure reasonable costs of operations.

#### **Recommendation 16:**

**\* The Board and Executive Director should take proactive steps to increase educational outreach and transparency.**

The Board and Board staff should take proactive steps to promote consumer outreach and transparency of processes in order to better carry out its mission to protect the public. Outreach efforts should be devised to help improve the quality and safety of patient care and thus prevent problems which otherwise could result in harm to patients and provider complaints. The Board should devise a plan to better educate and inform licensees and students about the licensing and regulatory processes. Emphasis should be placed on ways to maintain professional standards and avoid unprofessional conduct. Moreover, more efforts are needed to better inform constituents about the licensing and regulatory process. For instance, the Virginia medical board posts guidance documents on their website, which appear useful for both patients and providers. The website of the Maryland Board of Physicians has been improved, but much more is needed to make it easier to navigate and to have information more readily available. Staff should timely post such basic information as the annual report, open meeting agendas, minutes, Managing for Results (MFR) data, and data reported to StateStat. The staff should review the websites of other states, which can serve as models. The website should also include more informative guidance about the complaint process, the different types of discipline, the charging process, and time limits on what can be investigated. More information and action also is needed to better inform hospitals about what they should be reporting. The Federation of State Medical Boards offers educational programs and services that the Board staff should explore.

Further, a number of regulatory changes are still needed where practice is inconsistent with regulations. Stakeholders should be invited to participate earlier in the regulatory process in conjunction with Board members, Board counsel and staff members so that all views are considered.

**Recommendation 17:**

**The Secretary and Board should define the responsibilities and expectations of the Executive Director, who should be held accountable for agency operations.**

The Secretary and Board should collaborate on defining the responsibilities of and setting performance goals for the Executive Director. Before the end of each fiscal year, Board members and senior leadership in the staff agency should complete confidential evaluations of the Executive Director. The information should be provided to the Secretary and Board Chair for consideration in the annual evaluation of the Executive Director. As the agency administrator, the Executive Director must be the “watchdog” over the administrative staff to ensure effective agency operations. The Executive Director must regularly inform the Board and Secretary about agency operations, particularly any problem areas where intervention is required. For instance, turnover of investigators was a problem under the former agency leadership. If that should continue, the Executive Director should identify reasons and work with the Board and Secretary to resolve the problems.

The Executive Director should work with the Board in developing and implementing a strategic plan that moves the Board to the forefront of effectively discharging its important responsibilities, including such matters as increasing educational outreach to better inform licensees, students, and the public about the licensing and regulation processes; processes to streamline Board activities to more timely encourage resolution of complaints and assure the protection of the public; and topics and ways that Board members can become better informed on complex matters that come before the Board. The strategic plan could identify challenges and process improvements in dealing with matters that cross state lines, such as licensing issues and practicing telemedicine. The Secretary should regularly be informed of the progress of the plan and any changes that the Board believes are needed to better enable them to fulfill their duties, including any statutory changes.

**Recommendation 18:**

**The Board and Executive Director should consider further actions to enhance administrative functions.**

We offer the following suggestions to further improve the administrative functions supporting the Board:

- A. The Board staff should ensure that adequate specifications are developed for a new automated information system, which will be critically important in streamlining processes and ensuring timely and effective Board operations. The Board staff has begun efforts to acquire new computer software needed to efficiently track and analyze complaints and investigations and communicate with respondents and complainants as well as to replace the paper process currently used for original licensure requests. The staff should demonstrate to the Board and DHMH that it has undertaken a sufficient analysis of its system needs. Procuring new IT systems entails substantial efforts to assure that the acquisition is well planned to meet the Board’s long-term needs. A detailed needs assessment, including an analysis of database needs, tracking and analysis needs, system generated reports/letters, automating the licensing process, levels of security required

(since much of the data is confidential), etc. must be clearly articulated. The staff should discuss their plan with other Maryland health occupation board staff and staff of the Department of Information Technology who can provide outside expertise to better inform the process. Moreover, the system will only be as good as the data entered (which has been problematic in the past) and staffing must be reassessed as part of this process, including the need to improve data entry. Since the new IT system will not be available in the near-term, the Board staff should develop an intermediate plan/system to better track and report on investigations, caseloads and Board actions. An assessment of the costs and how they will be supported over a multi- year period is needed and should be reported as part of the budget request for FY 2014.

- B. The Executive Director needs to regularly assess staff training needs and promote enhanced skill building to help staff improve their performance and communication skills. Internal staff may be available to help guide and train other staff or web-based training could be used to support more general skill building needs. Outside training in more complex areas relating to investigations may be desirable. We understand that the Executive Director has asked staff to identify training needs and submit specific proposals. Some training has already been scheduled.
- C. DHMH/ Executive Directors should recommend better use of health occupation board resources. We understand that the Executive Directors of the health occupation boards meet monthly to discuss issues of mutual concern. It would be helpful for DHMH to report to the Governor and legislature on ways that the Boards can make more effective use of resources, such as, ways to improve operational efficiencies; potential increased sharing of streamlined processes, shared central IT systems, and ways to enhance educational outreach, etc.
- D. At the end of each fiscal year, the Board should submit to the Governor, DHMH, Maryland General Assembly and post on its website, a formal report that better informs licensees, policymakers and the public about its licensing and disciplinary activity for the past year. The legislature may want to set forth specific elements to be included in the annual Board report, which is required under the Health Occ. Art., Sec. 14-205 (b). The Federation of State Medical Boards sets forth detailed recommendations for what medical boards should report (illustrations are listed below). The Board staff should review the list to determine which they may be able to report on a monthly basis to State Stat and which should be included in an annual report:
  - Number of licensees by regulated field and number of those currently practicing;
  - Number of licensees by regulated field granted a license for the first time, the number currently practicing in the state, and the number of full licenses denied;
  - Number of licensees by type of license about whom a complaint was filed and the number by category found not to warrant action under statute and rules of the Board;
  - Number of disciplinary investigations conducted by the Board of licensees practicing in-state;
  - Number of disciplinary actions, by licensee type and category, taken by the Board;
  - Ranking, by frequency, of primary causes for disciplinary action against all licensees;
  - Any disciplinary activity related to holders of limited licenses;
  - A review of the Board's current mechanisms for dealing with licensees dependent on alcohol and other addictive substances;
  - A schedule of all current fees and charges;
  - A revenue and expenditure statement, showing the revenues and expenditures for each regulated profession;

- An overall summary of Board activities and a schedule of meetings of the Board and each of its committees;
- A summary of administrative and legislative activity;
- A summary of the goals and objectives established by the Board for the coming fiscal year; and
- A copy of the Board's strategic plan.



## **APPENDICES**





**APPENDIX A – Table of Summary Recommendations and State Entities Responsible for Action**

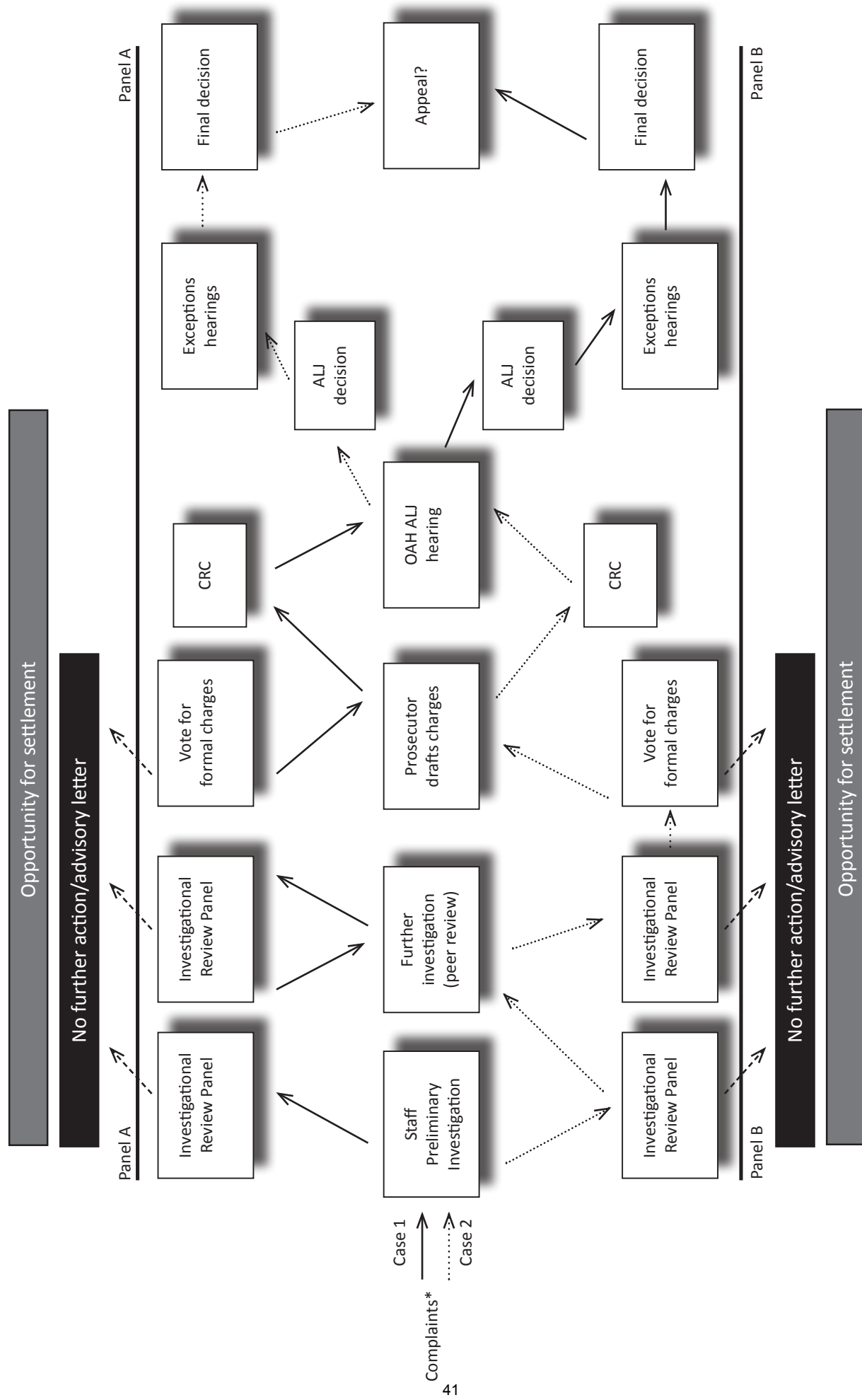
#	Summary of Recommendations  Note: Key Recommendations have an * (asterisk)	Action Recommended for					Office of Attorney General (OAG)	Office of Adm. Hearings (OAH)
		Maryland General Assembly	Maryland Board of Physicians (MBP)	MBP Staff Agency	Dept. of Health & Mental Hygiene (DHMH)			
1*	<u>Two Disciplinary Panels</u> : Amend Medical Practice Act for Board to implement two separate panels to hear disciplinary cases.	x	x					
2*	<u>Informal Settlements</u> : The Board should implement more informal processes for case resolution.		x					
3*	<u>Attorney Assistance</u> : The Board should have more access to OAG attorneys and opportunity to provide feedback regarding attorneys.		x				x	
4*	<u>Allied Health Professionals</u> : Allow representative of allied health profession advisory committees' to serve "ex officio" on panels when a member of that profession is subject to discipline.	x	x					
5*	<u>Timeframes</u> : Establish timeframes for Board, OAH and OAG.	x	x	x	x		x	x
6*	<u>Sanctioning Guidelines</u> : Revise as necessary, complete and implement as soon as possible.	x	x					

#	Summary of Recommendations Note: Key Recommendations have an * (asterisk)	Action Recommended for					
		Maryland General Assembly	Maryland Board of Physicians (MBP)	MBP Staff Agency	Dept. of Health & Mental Hygiene (DHMH)	Office of Attorney General (OAG)	Office of Adm. Hearings (OAH)
7	<u>Fraud &amp; Self-Referral</u> : The Board should acquire or develop expertise to handle fraud and self-referral cases.		x	x			
8	<u>Templates</u> : Draft templates for Board investigators to gather evidence.			x		x	
9*	<u>Peer Review</u> : Authorize Board to use only one peer reviewer.	x					
10	<u>Administrative Law Judges (ALJs)</u> : Designate a smaller, specially trained pool of OAH judges to hear Board cases and Board should assist with training.		x	x			x
11	<u>Policy Statement</u> : Provide a statement in statute guiding the actions of the Board.	x					
12*	<u>Board Members</u> : Increase the size and composition of the Board.	x	x				
13	<u>Training for Board</u> : Provide orientation and training for Board members.		x	x	x	x	x
14*	<u>Powers &amp; Duties of Board</u> : Consolidate and more clearly delineate the Board’s powers in statute.	x					

#	Summary of Recommendations Note: Key Recommendations have an * (asterisk)	Action Recommended for					
		Maryland General Assembly	Maryland Board of Physicians (MBP)	MBP Staff Agency	Dept. of Health & Mental Hygiene (DHMH)	Office of Attorney General (OAG)	Office of Adm. Hearings (OAH)
15*	<u>Board Committees</u> : The Board should establish committees for oversight of staff and special issues.		x				
16*	<u>Educational Outreach</u> : The Board and staff should take proactive steps to prevent problems and ensure transparency.		x	x	x	x	
17	<u>Executive Director</u> : Hold the Executive Director accountable.		x		x		
18	<u>Administration of Board Staff</u> : Take further actions to enhance staff functions and reporting.	x	x	x	x		



# APPENDIX B -Proposed Complaint Resolution Process



\*This chart reflects our proposal for two panels having parallel responsibilities. The solid and dotted lines represent cases and when those cases cross over to the other panel.



**APPENDIX C – Action on 2011 Sunset Review Recommendations as reported by Executive Director, Maryland Board of Physicians, July 2012**

<b>2011 Sunset Recommendations/Executive Director Proposed Actions</b>					
<u><b>Recommendation</b></u>	<u><b>Name Responsible</b></u>	<u><b>Proposed Start Date</b></u>	<u><b>Proposed End Date</b></u>		
1	Develop Managing for Results goals for allied health professions, to report on consumer satisfaction and licensure processing goals.	Deputy	Completed 1/23/12	The data capture and satisfaction survey and MFR were completed on 1/23/12.	
2	For CME audit, Board should select and notify licensee who has been selected in the renewal notice that the board is required to send to each licensee.	Regulatory Workgroup	5/1/12	<p>If a CME audit notice is combined with the renewal notice, licensees could theoretically fail to complete their CMEs because they would have advance notice that they are not subject to audit.</p> <p>To accomplish the Sunset Recommendation while aligning it with the MBP concern, the ED recommends changing the dates of CME completion requirements and renewal notices, and requiring CMEs to be completed by June 30 for September renewal, and sending renewal/audit notices after June 30. CMEs would then have to be completed prior to notices being sent.</p>	
3	The board should amend its regulations to reflect current fees.	Regulatory Workgroup, Ellen, Felicia	Review 5/1/12	3/1/13	<p>Meeting 5/29/12 Initial State comps completed. In progress: Salary comparison, and 2 year renewal cycle numbers. June 2012- Initial Fiscal assessment completed .</p> <p>Follow up information due July 2012</p>
4	Repeal assessment of fee for physician assistant rehabilitation program.	Regulatory Workgroup, Ellen, Felicia,	Review 5/1/12	3/1/13	<p>Meeting 5/29/12 Initial State comps completed. In progress: Salary comparison, and 2 year renewal cycle numbers.</p>

7/23/2012

					Follow up information due July 2012
5	Increase the involvement of allied health advisory committees in complaint resolution and licensee discipline. Uncodified language should require that the recommendations be submitted by the board to the Department of Legislative Services in a subsequent follow-up report.	Allied Health Workgroup		10/31/ 2012	This requires legislation.  Dr. Perman
6	Report complaint data for allied health professions in board annual reports and Managing for Results data in the same manner as reported for physicians.			<b>Completed January 2012</b>	Sanctions against allied health practitioners are included in the annual report. The future computer system will be able to capture this data; however, the current system does not have this capability.
7	Revise expedited complaint process for CME cases to include more Board involvement in process. Adopt regulations governing all expedited case resolution procedures. Include the amount of fines levied in the board's annual report.	Regulatory Workgroup	5/1/ 2012	3/1/ 2013	Revised complaint process for CME's currently being developed between Licensure, Renewal, and Compliance.  This requires legislation.
8	Review/modify expedited process for ground 21 and 24 disciplinary cases .	Regulatory Workgroup	5/1/ 2012	<b>Completed December 2011</b>	See Attachment (Ground 21 and 24)

7/23/2012



9	Adopt uncoded language to require DHMH and MBP to develop strategy for reducing complaint backlog by 12/12. MBP should report on progress.	Compliance Workgroup	5/8/12	<b>Completed April 2012 (Review stats July 2012, adjust as needed)</b>	<p>As of May 29, 2012- 300 cases reviewed, 100 cases closed and 60 cases sent to peer review.</p> <p>As of June 30, 2012 - 26 cases in-house; 50+ with OAG; 40+ reported separately (self-referral)</p> <p>Monthly OAG meetings to review cases.</p> <p>Reorganized the compliance unit into teams including a backlog team. Continuances granted only under exceptional circumstances. Monthly meetings with OAG to coordinate resolution strategy. Standardize case summaries, etc. Contract employee dedicated to tracking and support. Intake process streamlined.</p>
10	Expand the complaint database to track the sanctions, the date the board voted to charge in a way that can be more easily accessed; and Ensure data is entered completely.	IT Workgroup	May 10, 2012	12/3/12  <b>Vote Polling Sheet Completed 4/11/12</b>	<p>Purchase and implementation of medical licensure and complaint resolution software would greatly enhance the capability of recording and collecting meaningful data.</p> <p>Purchase Audio equipment.</p> <p>IT system- draft specs completed for leadership meeting on 6/4/12.</p> <p>Will continue to pursue July 2012</p>
11	Treat violations of probation and violations of orders as distinct, board-generated complaints; assign new complaint case numbers when the board learns of subsequent violations.	Compliance Workgroup	May 8, 2012	10/31/ 2012	<p>Designing a new case numbering system that will enable better tracking of multiple charges and violations of probation and orders, and is currently examining this issue.</p> <p>See Recommendation 17</p> <p>Preliminary Meeting with Kathleen Ellis on 5/22/12.</p> <p>Preliminary meeting with OAH 6/5/12</p>
12	Adopt Budget bill language to withhold funds from MBP until the board promulgates in regulations sanctioning guidelines for physicians and allied health professionals.	Regulatory Workgroup	7/1/13	12/3/12	<p>Review Sanctioning Guidelines- Approved 3/28/12</p> <p>Sent to AERL April 9, 2012</p> <p>Publication for comment June 1, 2012</p> <p>Regulations published June 2012</p> <p>Comment period ends July 2, 2012</p> <p>Standardize case summaries implemented June 2012, will</p>

7/23/2012

					include delayed details.  Effective January 17, 2012, a template for a detailed explanation of the reason for the delay of a case was implemented. Analysts are required to provide this explanation for each/any aging case. The development of comprehensive case summaries is ongoing.
13	Include in the record a detailed explanation of the reason for the delay for a complaint open more than year.	Compliance Workgroup	May 8, 2012 Case Summary meeting 4/27/12	7/30/2012	Analysts prepare comprehensive case summaries every 90 days including a summary of facts, processes completed and case status, resolution strategy including deadline dates, and complete explanation for delays in any part of the process. Standardize case summaries implemented June 2012, will include delayed details.
14	Disclose on the licensee profile. <ul style="list-style-type: none"> <li>filing of charges and</li> <li>notice of initial denial of a license application</li> </ul> Include a disclaimer stating that the charging document does not indicate a final finding of guilt by the board.			<b>Completed January 2012</b>	
15	Disclose to the public: <ul style="list-style-type: none"> <li>filing of charges against an allied health licensee; and</li> <li>notice of initial denial of an allied health license application .</li> </ul>			<b>Completed January 2012</b>	Charges and notices of initial denial for Allied Health practitioners were added to the website in January 2012.

7/23/2012

16	Amend regulations to allow complainant to appear before the board during a case resolution conference.	Regulatory Workgroup	5/1/12	12/3/12	<p>The ED recommends a comprehensive review of all regulations to align them with current practice. Board sent to Michele Phinney as part of hearing regulations.</p> <p>Scheduled for publication June 1, 2012</p> <p>Regulations published June 2012</p> <p>Comment period ends July 2, 2012</p>
17	<p>Adopt guidelines for reopening cases, especially sexual misconduct cases;</p> <p>Revise advisory letter when closing a sexual misconduct case;</p> <p>Institute better tracking mechanism for sexual misconduct cases; and</p> <p>Reopen relevant cases under original case number.</p>	Compliance Workgroup	May 8, 2012	10/31/2012	<p>Designing a new case numbering system that will enable better tracking of multiple charges, violations of probation and orders, and a pattern of behavior.</p> <p>See Recommendation 11</p> <p>Preliminary Meeting with Kathleen Ellis on 5/22/12.</p> <p>Preliminary meeting with OAH 6/5/12.</p>
18	Ensure that referrals to the Maryland Physician Rehabilitation Program do not specify length of participation.				The program now determines length of monitoring based on their evaluation.
19	Amend statute to authorize MBP to seek a warrant for entry into private premises as needed.	Statutory			The search warrant provision is rarely used in practice, and such searches can present serious safety issues for MBP investigators. MBP investigators share information, and align investigations, with law enforcement when necessary. The ED recommends deferring to the advice of OAG prosecutors and Board Counsel regarding the statutory and regulatory requirements and modifications

7/23/2012

					for searches.
20	Develop long term fiscal plan Report to DLS by December 31, 2012.	Fiscal Workgroup	May 3, 2012	12/3/12	Meeting held on 5/29/12 developed parameters. Fiscal Unit beginning 2012 close out; will continue detailed analysis July 2012 with 5-year projections.
21	Assess cost and fees for allied health practitioners.	Regulatory/Fiscal Workgroups, Ellen, Felicia,	5/1/12	3/1/13	<p>July 1, 2012 new cost code for Allied Health. Quarterly adjustment for overhead. DBM has limited number of cost codes; new computer system will further delineate Allied Health cost and revenue.</p> <p>The ED further recommends the addition of one additional full-time position (Executive Services unit) to coordinate the assessment and monitoring of costs specifically associated with the Allied Health unit and in carrying out all tasks associated with carrying out fee structure assessment addressed in other portions of this report.</p> <p>Preliminary assessment has been performed awaiting final FY2012 figures to complete.</p>
22	Assess fees needed to support allied health, especially initial license fee for athletic trainers.	Regulatory/Fiscal Workgroups, Ellen, Felicia,	5/1/12	3/1/13	<p>July 1, 2012 new cost code for Allied Health. Quarterly adjustment for overhead. DBM has limited number of cost codes; new computer system will further delineate Allied Health cost and revenue.</p> <p>The ED further recommends the addition of one additional full-time position (Executive Services unit) to coordinate the assessment and monitoring of costs specifically associated with the Allied Health unit and in carrying out all tasks associated with carrying out fee structure assessment addressed in other portions of this report.</p> <p>Preliminary assessment has been performed awaiting final</p>

7/23/2012

					FY2012 figures to complete.
23	Stop using contractual employees to perform ongoing functions of the board.			<b>Completed April 30, 2012</b>	<p>Contracted employees: One full-time fiscal (Executive Services), one full-time support staff reinforcement; one part-time medical consultant, and one part-time Compliance/Investigation backlog/tracking support.</p> <p>The ED recommends continuing the practice of hiring a limited number of contracted personnel to meet temporary needs, especially in carrying out tasks associated with this report and corrections needed pursuant to the 2011 Sunset Review.</p> <p>DBM has granted several recent exemptions; hiring into historically vacant positions is currently underway.</p>
24	Guidance for board staff re participation and attendance at closed meetings; and Eliminate RIP for applicants for reinstatement after a suspension.			<b>Staff meeting attendance Completed January 2012</b>	<p>ED continues to monitor attendance at meetings and the purposes therefore.</p> <p>Respondent appearances before the Reinstatement Inquiry Panel should continue for individuals whose suspensions involved serious or willful actions. These appearances give the board an opportunity to personally reinforce the gravity of actions that violate statutory and regulatory requirements.</p>
25	Amend statute to require online profiles on allied health licensees.	May 10, 2012	IT/Regulatory Workgroup	3/1/2013	Met and discussed changes that will be made to allied health profiles. IT is working on implementing changes.

<b>26</b>	<p>Improve the quality of its website. Post all required disciplinary actions.</p> <p>Post open meeting agendas, etc.</p> <p>Post Board staff names and</p> <p>Post how to obtain information about malpractice.</p>	IT, Tammy	May 3, 2012	<b>Completed April 30, 2012 (Revisions as needed )</b>	<p>The website now reflects required disciplinary actions, board and staff names, contact information for specific areas, and open meeting agendas and minutes. The board cannot provide comprehensive medical malpractice information because access to full information is from sources outside the board.</p>
<b>27</b>	<p>Standardize information and documents in hard copy investigative files. Include a checklist for documents in the file. Include dates corresponding with the steps in the complaint resolution process.</p>	Compliance Workgroup	May 8, 2012	October 31, 2012	<p>Preliminary changes have been made to the hard copy files and basic checklists were added. Additional storage boxes and files need to be purchased, and policies/procedures regarding creation and storage of documents need to be developed. The ED recommends a complaint resolution software package that will eliminate the requirement for hard copy files with the exception of only essential legal documents.</p> <p>As of April 2012, a standardized investigative file has been drafted. A checklist of documents as well as corresponding dates with the investigative steps is available through BPQA tracking system and should be maintained in the file.</p> <p>June 2012- Standardized case summaries.</p>
<b>28</b>	<p>Insure annual report consistent with MFR &amp; complaint database. Verify case and licensure numbers on closed minutes.</p>			<p><b>Compliance /Board Counsel cross-check Completed</b></p> <p><b>Vote Polling Sheet Completed 4/11/12</b></p>	<p>The Compliance Chief or assignee and Board Counsel now review minutes and cross check with case numbers for quality review of Managing for Results data prior to submission. The ED recommends purchase and installation of current audio equipment so that information</p>

7/23/2012

					can be accurately recorded.  Vote Polling Sheet to accurately record votes when Board is unable to reach a unanimous decision.
<b>29</b>	Train Board members and staff on Open Meetings Act. Board counsel review and approve closed and open meeting agendas; Board counsel to advise if the board begins to discuss an open meeting topic in closed session.	OAG, Board Counsel, Training/Outreach	May 7, 2012	Board Counsel advised 1/23/12	Board Counsel was advised of these requirements and expectations on January 18, 2012. Board Counsel is employed and assigned by the OAG, over which the MBP has no control. The ED further recommends that this component be included with training discussed below.  Established internal Outreach/Education Unit - April 2012  New Board training has been developed . Training will take place August 15 <sup>th</sup> and 29 <sup>th</sup> 2012
<b>30</b>	Improve board member training by developing training in conjunction with DHMH, OAG, and OAH; and Include training on parliamentary procedures.	OAG, Board Counsel, Training/Outreach	May 7, 2012	8/31/2012	The ED agrees and further recommends that, in conjunction with the above training, a Board guide be developed for continual reference during membership and loaded onto iPads that have already been distributed to members. Additionally, this training should be incorporated into staff training.  Established internal Outreach/Education Unit - April 2012  Next meeting May 31, 2012  New Board training has been developed. Training will take place August 15 <sup>th</sup> and 29 <sup>th</sup> 2012. OAG and OAH will be presenting and participating in training.

7/23/2012

<b>31</b>	<p>Require of each allied health advisory committee:</p> <ul style="list-style-type: none"> <li>• Annual report to the board;</li> <li>• Chair serve in an advisory capacity to the board; and</li> <li>• Chair report to the board on a biannual basis &amp; present the committee's annual report.</li> </ul> <p>Require of Board:</p> <ul style="list-style-type: none"> <li>• Written explanation to committee if recommendation not followed.</li> <li>• Biannual report on disciplinary matters involving allied health professionals.</li> </ul>	Allied Health Workgroup	<p>May 4, 2012 Committee Interviews 5/20/12.</p> <p>Contact rotary clubs by 5/3/12</p>	<p>7/30/12</p> <p>All proposed members on June 27 agenda.</p>	<p>Allied Health annual reports have already been captured in the MBP Annual Report, and there is general consensus that a Board member will serve on each committee and act as a liaison to the Board for information sharing; disciplinary data will be provided to the committee.</p> <p>Allied Health annual report will be placed on the August or September Board agendas.</p>
<b>32</b>	<p>Improve the recruitment of allied health advisory committee members.</p> <p>Provide an update on several allied health issues to DLS on 12/31/12;</p> <p>Recruitment efforts; appointment of members and chair, etc.;</p> <p>Recommendation on board members sitting on committees;</p> <p>Recommendation with respect to whether number of licensees should be considered when determining the size of a committee; and</p> <p>Recommendation on whether size and composition of the advisory committees</p>	Allied Health, Yemisi	May 3, 2012	12/3/12	<p>A meeting was convened on January 25, 2012 to discuss the use of website, letters to societies and hospitals, evaluation of committee member expiration dates, and filling all vacancies with committee Chairs being first priority, as well as board members serving on Allied Health committees. The ED recommends blast emailing licensees who have registered an email address with the board and contacting colleges/universities as well as allied health professional associations to recruit committee members.</p> <p>Consider removing Radiology Assistants from advisory committee.</p> <p>Requires Legislation</p>

7/23/2012



	should be altered through statutory amendment to more effectively carry out oversight functions.				
<b>33</b>	<p>Board should complete in a timely manner:</p> <ul style="list-style-type: none"> <li>• Appointment of members;</li> <li>• convening advisory committees; and</li> <li>• Development and adoption of regulations.</li> </ul>	Allied Health Workgroup	May 4, 2012	<p>Member Recruitment appointment by December 2012</p> <p>Regulations by 3/1/13</p>	<p>The Chief of the Allied Health unit is to fast track development of the Perfusionist committee and, with staff, begin developing regulations for committee consideration. Law not in effect until October 2012.</p> <p>CV's for two perfusionists and one physician to will be on the June on July Board agenda. One of the interested perfusionists is interested in assisting in recruiting others.</p>
<b>34</b>	<p>Amend statute to prohibit appointment to an advisory committee or Board of an individual who is providing or has provided services to the board for remuneration.</p> <p>Replace any individual currently serving on MBP or committee who has provided services to the board for remuneration.</p>	Regulatory Workgroup	May 1, 2012	7/1/13	<p>This recommendation may prevent individuals with unique knowledge and experience from serving the Board, however, the ED recognizes that these types of arrangements tend to give the appearance of impropriety and/or conflicts of interest to the public. The ED recommends that the Governor or Secretary be given the authority to provide a waiver for these individuals on a case by-case basis.</p>
<b>35</b>	<p>Identify nonmembers at Board &amp; Committee meetings.</p>			<b>Completed February 2012</b>	<p>For most, if not all, meetings, attendees are currently requested to identify themselves prior to meeting commencement. All attendees are required to introduce themselves during closed sessions. These procedures will be included in board member training discussed in other portions of this report.</p>
<b>36</b>	<p>Adopt regulations by December 31, 2012, on</p> <ul style="list-style-type: none"> <li>• exceptions to licensure for the purpose of</li> </ul>	Regulatory Workgroup	May 1, 2012	12/3/12	<p>This language has been drafted and will be included in the Sunset bill.</p>

7/23/2012

	<ul style="list-style-type: none"> <li>consultation;</li> <li>exemptions from licensure fees; and</li> <li>mental health record subpoenas.</li> </ul>				<p>AAG has provided a statement regarding inadequacy of statute to support regulations to allow out-of-state physicians to come into MD for training/teaching.</p> <p>Regulations for exemption from license fee discussed and regulatory unit will be drafting.</p> <p>Language regarding mental health records is in the proposed hearings regulations (10.32.02) and sanctioning guidelines for physicians; currently at AELR.</p>
<b>37</b>	Develop process for updating regulations .	Regulatory Workgroup	May 1,2012	<b>Completed 6/2012</b>	See attached.
<b>38</b>	<p>Amend statute to allow for current MBP practice for</p> <ul style="list-style-type: none"> <li>Accepting medical school teaching in lieu of postgraduate medical education; and</li> <li>failure to pass the required examination.</li> </ul>	Regulatory Workgroup		7/1/2013	The ED recommends a comprehensive review of the regulations
<b>39</b>	<p>Amend statute on Drug Therapy Management to eliminate the requirement that physician-pharmacist agreements and protocols be approved by the State Board of Pharmacy and MBP.</p> <p>MBP &amp; Bd of Pharmacy submit a follow-up report to EHEA &amp; HGO committees by October 1, 2013, on the impact of these modifications to the drug therapy management program,</p>	Statutory		<b>Completed 6/30/12</b>	<p>Board approved at June 2012 meeting.</p> <p>Report due October 1, 2013.</p>

7/23/2012

<b>40</b>	Self-referral: Work with Maryland Insurance Administration, the Office of the Attorney General, and DHMH Office of the Inspector General to determine the appropriate entity for investigating and enforcing; and Report findings to the DLS	Carole, Wynne, Board Counsel, Bob	May 1, 2012	12/3/2012	Meeting with assigned OAG prosecutors and analysts- March 2012  Meeting May 10, 2012 to finalize documents for subpoenas.  Final interview by July 30, 2012
<b>41</b>	Amend statute to authorize MBP to impose civil fines against alternative health systems that fail to report as required by the section. Amend statute to clarify how the court reporting requirement is to be enforced and place the requirement in a separate statutory section.	Regulatory Workgroup	May 1, 2012	3/ 1/ 2013	
<b>42</b>	Six month reports under § 14-413 and 14-414: Report every six months regardless of adverse actions taken. Simplify its reporting form. Conduct outreach with the facilities on this issue. Assess civil fines against non-reporters. Create and post on the board's website a Report of Disciplinary Action form for allied health licensees.	Regulatory Workgroup, IT Training/Outreach	May 7, 2012	Statute: March 1, 2013  Revise Reporting Form September 30, 2012  Website Revision September 30, 2012  Outreach October 31, 2012	The ED agrees with the recommendation and believes that enhancements to its website discussed in other portions of this report can be utilized for this purpose. Additionally, a data entry/reporting mechanism should be created to capture data in a standardized format.  Established Outreach/Education Unit - April 2012  Meeting with IT workgroup on 5/10/2012  See also Recommendation 41
<b>43</b>	Change statute to accommodate conventional practice of athletic training: Allow outside referrals; Specify which licensed	Regulatory Workgroup	May 1, 2012	<b>Completed 7/1/2012</b>	

7/23/2012

	health care provider referrals are allowed; and Clarify the acceptable mechanisms that a physician may use to supervise an athletic trainer.					
<b>44</b>	<p>Uncodified language requiring the board, to adopt regulations by December 31, 2012, for determining; what constitutes an advanced duty; how many successful procedures a physician assistant must perform to be deemed able to safely perform a delegated medical act.</p> <p>PAAC should:</p> <ul style="list-style-type: none"> <li>• Complete list of advanced duties the board has approved in the past;</li> <li>• post the list of advanced duties on the board's website;and</li> <li>• Attach list addendum application and delegation agreement application to perform core duties.</li> <li>• Decide all questions by PAAC as a whole should make the determination.</li> </ul>	Regulatory Workgroup	May 1, 2012	12/3/2012	<p>An advanced duties list is already on the board's website, and a regulation can be developed for the determination of an advanced duty. Including specific advanced duties in regulation would not allow the expeditious expansion of approved advanced duties due to the complicated process of regulations promulgation. Therefore, (2) should not be included in a regulation which will have to be continually modified, but rather, new advanced duties be posted on the website and updates sent by blast email to licensees.</p> <p>This requires legislation.</p>	
<b>45</b>	Adopt uncodified language requiring the board to license individuals enrolled in an unaccredited radiation therapy, radiography, or nuclear	Regulatory Workgroup			MBP does not have the academic resources to evaluate these types of educational programs, nor does the Radiology Technician Committee. The educational program that this recommendation refers to had been	

7/23/2012

	medicine technology program on 10/1/2010, and who graduate by 6/30/14.					aware of the Board's requirement of accreditation and was granted one grace period.
<b>46</b>	<p>Amend statute to extend the termination date for Board and Committees through 7/1/14.</p> <p>Further, uncodified language should be adopted to (1) clarify that the statutory requirements regarding preliminary and full reviews of MBP do not apply; (2) require MBP to submit a follow-up report to the Department of Legislative Services by June 1, 2013, that addresses the implementation of the recommendations made in this report, including any issues specifically noted for inclusion in the subsequent follow-up report; and (3) require the Department of Legislative Services, by October 1, 2013, to make a recommendation regarding further extension of the termination date based on the progress of MBP in complying with the recommendations of this report and the submission of the follow-up report by MBP.</p>	Regulatory Workgroup				

7/23/2012